

THE CLIENT'S HELICAL PATH:  
A GROUNDED THEORY OF UNSUCCESSFUL THERAPY EXPERIENCES

A Thesis Submitted to the  
College of Graduate Studies and Research  
In Partial Fulfillment of the Requirements  
For the Degree of Doctor of Philosophy  
In the Department of Psychology  
University of Saskatchewan  
Saskatoon

By  
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## **ABSTRACT**

A grounded theory methodology, justified by the logic of methodical hermeneutics, was employed to guide both the collection and analysis of data produced from interviews with 11 psychotherapy clients who reported having unsuccessful experiences. Ultimately, I put forth the “Client’s Helical Path” as a theoretical model grounded in clients' unsuccessful therapy experiences. The theory subsumes four subcategories: three cyclically-related subcategory processes (Embarking, Evaluating, and Ending), and a fourth category (Familiarity) that provides a temporal/experiential dimension. Clients embark upon a course of therapy with certain expectations; they later evaluate their experience on the basis of these expectations, and then end therapy when they adjudicate it as not sufficiently successful. Clients' familiarity with the enterprise of therapy is enhanced with each successive therapy experience, and this familiarity implicates clients' subsequent expectations, evaluations, and endings. The theory contextualizes clients’ experiences of unsuccessful therapy at the level of the individual, rather at the level of the course of therapy, thereby providing an understanding for how past therapy experiences influence future ones. This feature of the theory represents a significant departure from and contribution to the existing psychotherapy research literature. I discuss the unique nature and utility of the theory, its overlap with existing empirical findings, as well as its limitations. I suggest directions for future research, and I provide multiple credibility checks.

## **ACKNOWLEDGMENTS**

I am deeply grateful to the clients who volunteered to participate in this study. The eloquence and poignancy with which they engaged in reflexive explorations of their therapy experiences amazed, yet did not surprise, me. Their voices opened my eyes to certain experiences and perspectives of clients to which I was previously blind.

I consider myself so very fortunate to have met and to have worked with Linda McMullen, my research supervisor. Linda has many gifts of which I have become aware over the past few years, and not the least of these is her exquisite ability to develop genuine, meaningful, and satisfying relationships with others in her world, seemingly without any effort at all. When talking with Linda (often uninvited!) about a new inspiration, a most personal frustration, or simply a whimsical inclination, I have felt, without fail, welcomed, comfortable, and most of all, truly listened to. The reassurances that Linda has provided to me over the course of our relationship have had a profoundly calming and empowering impact on me, for which I am truly grateful.

I wish to pay tribute to the other members of my advisory committee, each of whom has demonstrated genuine interest in and steadfast support of my research from its inception. Their guidance of me, and faith in me, was instrumental in bringing this research to a successful conclusion. In particular, I am grateful to Brian Chartier for putting forward such thoughtful and provocative questions that encouraged me to focus on ideas that I had not previously considered, to Patti McDougall for her most valuable and trenchant critiques of my work that were offered in a manner that always left me feeling validated and supported, and to Stella Blackshaw for her willingness to support

and participate in my research and to trust me, even at times when my methods likely appeared highly unorthodox.

David Rennie's incisive and thoughtful writings about grounded theory methods and methodology have intrigued me for years, and he has thus provided me with a foundation upon which I have begun to build and solidify my own understandings. It was an honour to have him act as my external examiner, and I am especially grateful for comments he made that added to my understanding of both the content area and myself.

I am grateful for having received a Doctoral Fellowship from the Social Sciences and Humanities Research Council of Canada, a Graduate Teaching Fellowship from the University of Saskatchewan, and a Saskatchewan Health Bursary from the Government of Saskatchewan. Without such financial support, I would most certainly not have been able to complete my doctoral studies.

I want to thank Pat O'Neill for providing to me the initial inspiration to pursue a career in psychology, and for helping me get to where I am today. My children, Blaine, Tyler, and Simone, have struggled to make sense of the many ways in which my personal and professional journeys have sometimes negatively affected their lives, for which I am profoundly sorry. It is my hope that, in time, they will appreciate how commitments to one's self and to one's family are often not fully compatible, but that I must honour both in an effort to become a better father. Finally, I am eternally grateful for the words and acts of encouragement and support that my wife, Carrie, offered to me, both at times when I needed them and at times when I selfishly wanted them. The feedback that she provided on my thinking, my writing, and my graphics was invaluable.

## **DEDICATION**

*To My Wife, Carrie ...*

For tenderly demonstrating how *to love*;

For waiting ever so patiently as I learned how *to be loved*;

For allowing me to experience – for the very first time – the magic of being *in love*.

... *SCS*

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Concerning the psychology of the creative act itself, I have mentioned the following, interrelated aspects of it: the displacement of attention to something not previously noted, which was irrelevant in the old and is relevant in the new context; the discovery of hidden analogies as a result of the former; the bringing into consciousness of tacit axioms and habits of thought which were implied in the code and taken for granted; the uncovering of what has always been there.

This leads to the paradox that the more original a discovery the more obvious it seems afterwards. The creative act is not an act of creation in the sense of the Old Testament. It does not create something out of nothing: it uncovers, selects, re-shuffles, combines, synthesizes already existing facts, ideas, faculties, skills. The more familiar the parts, the more striking the new whole.

– Arthur Koestler (1964, pp. 119-120)

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## **CHAPTER ONE:**

### **SITUATING THE RESEARCH**

#### **1.1 The Intrigue of Unsuccessful Therapy**

Unsuccessful psychotherapy is, by definition, the antithesis of the fruitful outcome that therapists, clients, and the organizations that play host to the practice of psychotherapy intend, desire, and likely expect. These parties all have a vested interest in psychotherapy being ‘successful.’ But what about when psychotherapy is not successful? What is that experience like for the stakeholders?

Relatively little has been written about unsuccessful psychotherapy, and it is the perspective of therapists that researchers have relied upon most frequently in the vast majority of the writings that do touch on this undesirable manifestation of professional helping. As with most writings on psychotherapy process and outcome, the voices of clients have gone unheard (see Anderson, 1996; Bachelor, 1995), a concern that was articulated as early as the 1950s by theorists such as Carl Rogers (e.g., Rogers, 1951). Each “evaluative source” (e.g., therapist, client, observer) often has a different perspective on aspects of psychotherapy (see Elliott & Shapiro, 1992), and it is the overlooked perspective of clients with which I am most interested.

To be clear, my intrigue with unsuccessful therapy does not reflect a nay-saying or pessimistic stance with respect to psychotherapy (for readers interested in such a perspective, see Dineen, 2001). I have no vested interest in demonstrating or documenting psychotherapy as an inherently unsuccessful enterprise, which, based on

the evidence and my clinical and personal experiences, I do not believe it to be (see also Seligman, 1995). Rather, I recognize that it is rare that we experience any undertaking as entirely or uniformly successful, with psychotherapy being no exception. As Mohr (1995) has pointed out, virtually all therapeutic interventions, from aspirin to laser surgery, have, at times, negative outcomes. Moreover, it seems quite plausible that predicated upon an interest in making psychotherapy optimally successful, there is much to be learned from examining unsuccessful instances. Mohr supported this assertion, and offered as evidence the unsuccessful case of Dora, a patient of Freud, through which the robust concept of transference was first identified and articulated.

## **1.2 Purpose of the Current Research**

The present study explores clients' experiences of unsuccessful psychotherapy, and culminates in the production of a theoretical model representing the voices of clients who have had such experiences. This goal of 'theory-generation' may at first blush seem to be somewhat grand for a research endeavor at the dissertation level. However, theory-generation is a more common (albeit often implicit) aspect of many forms of research. Some have considered even the writing of a biography as, in fact, a process of theory generation (e.g., Smith, 1993).

The generation of a substantive theory (rather than a formal theory) is, indeed, a manageable and appropriate goal for a research endeavor such as this one. Glaser and Strauss (1967) proposed that substantive and formal theories both "fall between the 'minor working hypotheses' of everyday life and the 'all-inclusive' grand theories" (p. 33). The difference between these two types of theories, though, is that a formal theory

presents somewhat greater levels of abstraction, and is usually predicated upon examination of more than one substantive area of focus. In the current study, the scope is limited to one substantive area of focus: clients' experiences of unsuccessful psychotherapy. The goal of this research was to ultimately produce an "integrated set of conceptual hypotheses" (Glaser, 1992, p. 16) that relate the conceptual categories and their conceptual properties that emerged from the data collected within the substantive area under study. In other words, this research produced a theory of clients' experiences of unsuccessful therapy.

### **1.3 An Exercise in Bracketing**

#### **1.3.1 Enhancing Objectivity through Reflexivity**

Rennie (1995a) put forward the art of rhetoric as one that authors, including social scientists, rely upon to advance their arguments and to persuade their readers. Understood in this way, rhetoric is consistent with the philosophical position of relativism, because it highlights the differing perspectives among authors and readers. To successfully persuade their audiences, according to Rennie, authors (in this context, researchers) must convince their readers of the credibility of their work by demonstrating that they have used 'appropriate' or 'received' means to this end. The acceptable means of producing credible research are determined, and in fact dictated, by the populous scientific community, which at this time, embraces the canons of natural science. Consequently, Rennie argued that human science researchers need to develop a rhetoric of their own.

According to Rennie (1995a), the human science rhetoric requires researchers both to be reflexive in their investigations, and to demonstrate and communicate the results of such action to their readers. The predominant community of ‘natural science thinkers’ has not warmly received reflexivity, because it has been (mis)understood to represent an infraction of the canon of objectivity. However, Rennie suggested that such an interpretation reflects a muddling of the terms ‘objectivism’ and ‘objectivity.’ Objectivism is a metaphysical idea that reality exists outside of the mind and, following from that premise, leads to the call for clear (and attainable) separation between the object and the subject. Objectivity, on the other hand, has been conceptualized as the freedom of bias with respect to the researcher’s understanding, with the essential caveat that the researcher’s bias can never be fully eliminated from his or her understanding.

Some (e.g., Moustakas, 1994) have advocated the use of ‘bracketing’ techniques to identify and to hold at bay the assumptions, biases, and preliminary hypotheses of the researcher with respect to the content area under investigation (see also Rennie, 1995a, 1999, 2000). Techniques such as bracketing, therefore, allow researchers to demonstrate their commitment to, and the value they place on, reflexivity, thereby enhancing their objectivity without requiring them to adopt (or even accept that it is possible to adopt) an objectivistic stance. I concur with the utility of bracketing with respect to attempts to achieve (even if not fully) the former goal (elucidation), but I am less convinced that bracketing, or any other technique, allows us to achieve the latter goal (isolation). This research project presented to me several challenges with respect to translating my conceptual understandings of qualitative research, including aspects of both methodology and method, into a tangible, doable form (see Section 3.1 for my



elaboration of this point). My exercise in bracketing was one such challenge, and the others included writing the research proposal, employing the method of constant comparison (to be discussed later), and writing the theory.

With respect to bracketing, I struggled to determine the most appropriate form and content of my presentation. I resolved to present my philosophical assumptions, my research and clinical histories, and my pre-existing assumptions, biases and hypotheses about the content area of the current research. My goal is to present aspects of myself - as researcher - that are likely relevant to readers who wish to understand and critique the hermeneutic lens through which I conducted this study and, ultimately, produced the theory. Such reflexive action, therefore, “increases rather [than] decreases the credibility of the assertions being made” (Rennie, 1995a, p. 326; see also Rennie, 1996).

### **1.3.2 Philosophical Assumptions**

In both qualitative and quantitative modes of inquiry, the philosophical assumptions and leanings of the researcher are often not adequately addressed. Perhaps some researchers are not encouraged (or, perhaps, even discouraged) to disclose explicitly their philosophical stances, or perhaps they simply do not see any need to do so. When such core research and researcher issues go unaddressed, the consumers of research must make a guess as to assumptions held by the researcher, which are central to understanding, interpreting, and evaluating the nature and quality of the knowledge put forth.

I have adopted a constructionist paradigm of inquiry for the current investigation, in which I sought out clients’ retrospective self-reports of their unsuccessful therapy

experiences. Kuhn (1970, p. 175) defined a paradigm as “the entire constellation of beliefs, values, and techniques shared by members of a given community.” I believe that when operating within this paradigm of inquiry, it is neither possible nor prudent for researchers to adopt an objectivistic stance (see previous discussion), but I also agree with Rennie (1995a) that my chosen paradigm of inquiry does not prohibit me from making efforts to achieve a certain degree of objectivity. Nonetheless, it is inevitable, in my opinion, that researchers influence the products of their research.

Over the last several years, I have been accelerating away from realism, the doctrine that objects have a real existence independent of perception and thought, and toward relativism, the doctrine that every known object is relative to the knower. This philosophical shift has had a significant influence on (and also has been influenced by) the changing nature of my research interests and approaches, which I will discuss in the following section (1.3.2), and the changing nature of my clinical thinking. When I was first exposed to the taxonomy of mental illnesses, represented by the *Diagnostic and statistical manual of mental disorders - Fourth edition* (American Psychiatric Association, 1994), during my undergraduate training, I interpreted the various ‘diseases,’ or ‘maladies,’ contained therein to be ‘real’ entities. Indeed, the language of psychiatry and psychology frequently reifies the contents of this taxonomy in support of such an interpretation (e.g., “John *has* a personality disorder”; “it *is* depression that is at the root of Jane’s difficulties). As I continued my training, and accumulated more experience and knowledge, I came to question the objective, real nature of this taxonomic structure (see Szasz, 1960 for a landmark challenge to the prevailing understanding of mental illnesses as real entities).

To me, an undeniable piece of evidence in favour of an interpretation of the *DSM* as, at least in part, a socially-constructed taxonomy is the elimination (since the publication of the revised third edition) of the diagnosis of ‘homosexuality,’ which a vote of the APA membership ultimately brought about. This provided me with a tangible demonstration of the ways in which our individual ‘realities’ are, in fact, constructions that are susceptible to and products of cultural and historical factors (see Gergen, 1985). It was a demonstration of relativism. Certainly, a competing interpretation, utilizing a positivistic framework, is that we are able to continually improve upon our flawed understandings of reality (in this case, a taxonomy of mental illness) over time and after multiple investigations, as we produce closer and closer approximations of some absolute truth. I reject this interpretation and the positivist paradigm of inquiry that underlies it, however, because I do not believe that the history of science offers any compelling evidence that the changes in the approaches to, or products of, inquiry have been of a linear nature, as we would expect based on a positivist doctrine (see Robinson, 1986 for an in-depth and historically-contextualized exploration of various paradigmatic emphases and outcomes).

Further, there is no reason to believe that the historic *APA* vote on the veracity of the homosexuality diagnosis produced a unanimous verdict. Logically, therefore, we can infer that there were at least two camps within the *APA* voting membership: Those who believed (or, at least, voted in a manner) that homosexuality was a mental illness, and those who did not. Thus, this example, demonstrates another fundamental philosophical understanding that I have developed. Although I reject the notion of absolute truths, I do believe that there are local truths, or shared understandings, that are held by and that

dominate communities of individuals and specific cultural and historical contexts. In sum, it is not a radical relativist position that I hold. Rather, it is the case that I position myself much closer to the relativist end of the realist-relativist continuum.

With respect to the current study, my philosophical stance implies that I do not believe that there is some universal ‘truth’ about clients’ experiences of unsuccessful therapy. Rather, I believe that some clients interpret their therapy experiences as unsuccessful, and that they have differing ways of representing and communicating such experiences. Hence, the participants in this study provided me with their constructed accounts of their unsuccessful therapy experiences, which I then constructed into a theory grounded in their representations and, hopefully, grounded in the phenomenon itself. Put another way, I interpreted the personal interpretations of the participants. Rennie (2000) identified this as the ‘double hermeneutic,’ and stated further that:

as agents, people may choose the way in which they represent their experience, and, indeed, may opt either to misrepresent it or not to disclose it. Regardless of the extent to which persons are prepared to represent their experiences in ‘good faith,’ the experience is both constituted in part and influenced by interests, values, beliefs, and so on. In this sense, people are made to be interpreters of their experience of themselves. (pp. 483-484)

As Guba and Lincoln (1994) have emphasized, we must accept beliefs such as those I have presented here on faith. They are, and we can only understand them as, philosophical assumptions. Although they are not truths, they are essential for

contextualizing my constructionist paradigm of scientific inquiry (see also Becker, 1996). I will revisit my philosophical position in Chapter Two, in a discussion of how methodical hermeneutics (Rennie, 2000) is able to reconcile the tension between realism and relativism.

### **1.3.3 Research History**

I have translated my longstanding interest in the interpersonal dynamics of helping relationships into a continually developing program of research. My research initially explored the nature of the physician-patient relationship by investigating how various personal qualities of each member of the dyad could "fit" together to produce the most satisfying interaction (Shaw & O'Neill, 1997). Following this, I shifted the context from medical health relationships to those found within the enterprise of psychotherapy, and specifically focused on the manifestation of collaboration between therapist and client (Shaw, 1999a).

As the focus of my attention has shifted, so has my approach to research evolved. When investigating physician-patient relationship, I relied solely on the quantitative methods that were, not unusually, the sole focus of my undergraduate training in research design and methods. After working as a research assistant on a project that used qualitative methods of data analysis (O'Neill, 1998), my interests quickly shifted to the research possibilities that were present when one takes a step away from the "received view" (e.g., Stiles, 1993). My duties working on this project included working closely with the data, and thematically analyzing research interview transcripts (Shaw, 1999b). The wealth of rich information gleaned through such interviews profoundly impacted on

me. This experience provided sufficient exposure to the world of qualitative research to allow me to attempt a descriptive study of therapist-client collaboration in psychotherapy.

The process of my qualitative inquiry of therapist-client collaboration was fascinating and instructive. My research design required me to become familiar with, and successfully navigate the challenges and complexities of, conducting unstructured research interviews using the Interpersonal Process Recall technique (e.g., Elliott, 1986; Kagan & Kagan, 1991). I came to understand the frustrations and time commitment associated with transcribing 24 two-hour interviews. I struggled with how to even begin to approach the voluminous data set that the interviews created. And, in the end, I managed to construct a lengthy narrative of therapist-client collaboration, relying heavily on the voices of both therapist- and client-participants.

Although I ‘stayed close to the data’ throughout my thematic analysis, the narrative that I eventually constructed, while seemingly interesting and informative, was to a large extent a reflection of who I am. My thoughts, feelings, clinical experiences, and previous academic exposure to the content area were manifest in both the structure and content of the final research product. Unfortunately, I did not systematize my approach to working with the data, to avoid the resulting conflation of the narrative and the researcher.

Kagan and Kagan (1991) proposed that the inquirer must assume that interviewees have a great wealth of knowledge that is not obvious to an observer. The inquirer’s role, therefore, is to facilitate the process of interviewees making explicit that which they already know, but rarely acknowledge knowing. But the process of

interviewing also brings to the surface that which the interviewer already knows, but may have not acknowledged knowing. Even after explicitly adopting a research stance of “not-knowing,” I recognize that I brought to this project an understanding and a set of assumptions about therapist-client collaboration that undoubtedly influenced the ‘findings’.

I began the study holding impressions of what collaboration means, in the context of psychotherapy, from both theoretical and clinical perspectives. I endeavored to be vigilant about those pre-existing impressions so that I was also aware of ways in which they tended to influence my questioning of participants (and, therefore, the participants’ responses) during the research interviews. As Chenail and Maione (1997) commented, researchers who are also practitioners “have to come to grips with how they are going to manage their previously acquired knowledge in their soon-to-be area of research” (p. 1). Reflecting upon my study on therapist-client collaboration, I am not confident that I truly came to grips with this challenge.

Consequently, I arrived at a turning point in my research career where I sought new methods both to answer my research questions and to fit with who I am, as a researcher. As McMullen (1995) has stated:

The decision to ask particular kinds of questions, to use a particular method (or methods), resides in the combination of the researcher’s values, goals, training, and experience with the subject matter that is present at a given point in time. (p. 168)

Specifically, I needed to adopt a methodology that would allow me to straddle the divide between realism and relativism in a systematic, logical, and philosophically justified manner. I continue to strive to avoid the hazards of methodolatry<sup>1</sup> by allowing my research interests and my self-understanding to guide my choice of method, rather than have a particular (received) method guide my choice of research interests and exact undue influence on my development as researcher and the research findings that I produce.

#### **1.3.4 Clinical History**

My clinical training through the doctoral program in clinical psychology at the University of Saskatchewan has been of a generalist nature. I have completed rotations in a variety of settings, including psychiatric, forensic, and rehabilitation hospitals, hospital-based clinics, counselling agencies, and a private practice. The focus of my clinical training has included adult and child individual psychotherapy, process group psychotherapy, adult rehabilitation and psychiatry, neuropsychology, geriatric psychology, forensic psychology, developmental psychology, and community consultation. I am currently employed in a community mental health centre, which

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<sup>1</sup> The term ‘methodolatry’ appears to have been introduced by feminist philosopher and theologian Mary Daly, and is typically used to point to the idolatrous worship of particular methodologies by a discipline, which in turn limits its researchers’ choices of research questions (see also Bruner, 1990; Danziger, 1990; Elliott, Fischer, & Rennie, 2000)



provides both in-patient and out-patient services. I devote approximately half of my time to youth forensic services, and the other half to adult mental health services. I perform a slightly greater number of hours of treatment than I do assessment services.

With respect to theoretical orientation, I define myself as a ‘technical eclectic.’ Over the course of my training, the various knowledge and experiences that I accumulated informed me that any given theoretical orientation seems more or less appropriate and effective depending on the specific clinical context (including dynamics of the patient population, the clinical setting, external restrictions on service delivery, such as number of sessions allotted, etc.). Moreover, I developed an understanding that the ‘fit’ between therapist and patient might not be optimized if the therapist’s theoretical orientation mandates certain inflexibilities in the therapist’s thinking or doing. I recently wrote (Shaw, 2002) that I have come to accept and embrace my eclecticism, and I do not believe that this clinical *modus operandi* represents inner conflict, fence-sitting, pants-flying, or befuddlement, as some have argued. Instead, I believe that my technical eclecticism represents an effort to optimize the therapeutic fit between each patient and me.

### **1.3.5 Assumptions, Biases, and Hypotheses**

Consistent with my constructionist paradigm of inquiry, I do not believe that it is ever fully possible to separate out the knower from that which is known. Consequently, and as stated previously, I question how well the bracketing procedure can truly accomplish its second goal (as described by Moustakas, 1994) of ‘holding at bay’ the assumptions, biases, and preliminary hypotheses of the researcher with respect to the

content area under investigation. However, the process of articulating these pre-existing (relative to the time line of the research study) beliefs serves at least two additional purposes (notwithstanding that the limits of the researcher's self-awareness necessarily constrain such an articulation). First, it heightens the researcher's awareness of and sensitivity to the ways in which who she or he is might influence the various decisions that he or she will make as the research project unfolds. Decisions that are open to such influence may include the types of questions asked during interviews, the nomenclature of and relations among categories chosen to represent the data, and the identification of a core category, to name but a few. Second, it better equips readers to judge for themselves the degree to, and ways in, which the person of the researcher has influenced the final product of the research.

After having my research proposal accepted by my committee, but before conducting interviews with participants, I attempted to articulate my existing assumptions, biases, and hypotheses about unsuccessful therapy. Further, although this research project is focused upon unsuccessful therapy, I chose to repeat this sub-component of bracketing with respect to my beliefs about successful therapy. My personal experience has taught me that searching out and articulating my beliefs about the obverse of an issue provides me with greater clarity about the focal issue.

I utilized a 'brainstorming' approach to accomplish this portion of my bracketing exercise. Over a several-day period, I made notes of any thoughts about either successful or unsuccessful therapy, from both a therapist's and a client's perspective. With respect to the process of performing this element of my bracketing exercise, I found it much easier to automatically access or spontaneously generate the perspective of the therapist,

than to generate the perspective of the client. Although I have occupied the chair of both therapist and client at various times in my life, it appears that my more recent immersion into the world and role of the therapist has shaped my current perspectives more so than my more dated experiences as a client have done.

The product of this exercise was a highly disorganized assortment of beliefs. Consequently, I performed a theme-based reorganization of the content. For each of the two perspectives (i.e., therapist and client), I identified three domains of beliefs: definitions of successful and unsuccessful therapy, attributions about what is responsible for successful and unsuccessful therapy, and the personal impact of having experienced successful and unsuccessful therapy. The returns from this element of my bracketing exercise are presented in Tables 1-1 through 1-6.

**Table 1-1**

**Bracketing definitions of successful therapy**

<b>PERSPECTIVE</b>	<b>ASSUMPTIONS, BIASES, HYPOTHESES</b>
<b>Therapist</b>	<ul style="list-style-type: none"><li>• Client attained therapeutic goals</li><li>• Change in client effected</li><li>• Client gains insight; Client's distress reduced</li><li>• Client's adaptive functioning enhanced</li><li>• Client's quality of life enhanced</li><li>• Client satisfied with outcome</li><li>• Therapist satisfied with outcome</li><li>• Client's hope restored</li></ul>
<b>Client</b>	<ul style="list-style-type: none"><li>• Client attains treatment goals</li><li>• Client feels better</li><li>• Client's life satisfaction increased</li><li>• Client feels more able to cope</li><li>• Client develops greater/new self-understanding/insight</li><li>• Client experiences sense of self-efficacy</li></ul>

**Table 1-2**

**Bracketing definitions of unsuccessful therapy**

PERSPECTIVE	ASSUMPTIONS, BIASES, HYPOTHESES
<b>Therapist</b>	<ul style="list-style-type: none"> <li>• Client did not accomplish what had been negotiated</li> <li>• Client did not experience change</li> <li>• Client did not accomplish what therapist believed was possible</li> <li>• Client did not accomplish what he/she believed was possible</li> </ul>
<b>Client</b>	<ul style="list-style-type: none"> <li>• Did not accomplish what he/she had intended</li> <li>• Did not enjoy or benefit from T-C relationship</li> <li>• Did not experience change</li> <li>• Symptoms became worse than pre-therapy</li> <li>• Cost exceeded benefit</li> <li>• Time and energy commitments exceeded gains/benefits</li> </ul>

**Table 1-3**

**Bracketing attributions for what is responsible for successful therapy**

PERSPECTIVE	ASSUMPTIONS, BIASES, HYPOTHESES
<b>Therapist</b>	<ul style="list-style-type: none"> <li>• Therapeutic alliance; Collaboration; Non-specific factors</li> <li>• Empirically-validated treatments; Eclecticism</li> <li>• Match between presenting problem and modality</li> <li>• Match between client characteristics and modality</li> <li>• Therapist training/expertise</li> <li>• Client motivation to change; Client readiness</li> <li>• Negotiation of realistic therapeutic goals</li> </ul>
<b>Client</b>	<ul style="list-style-type: none"> <li>• Client's own motivation to change</li> <li>• Client's readiness to change</li> <li>• Non-specific factors in therapeutic relationship</li> <li>• Therapeutic alliance; Expertise of therapist</li> <li>• Factors external to therapy (in client's environmental system)</li> <li>• Length of therapy; Characteristics of the agency</li> <li>• Therapeutic modality fits with client characteristics</li> <li>• Therapeutic modality fits with presenting problems</li> <li>• Support from individuals/systems other than the therapist</li> </ul>

**Table 1-4**

**Bracketing attributions for what is responsible for unsuccessful therapy**

PERSPECTIVE	ASSUMPTIONS, BIASES, HYPOTHESES
<b>Therapist</b>	<ul style="list-style-type: none"> <li>• Client was resistant; Client not ready for therapy</li> <li>• Therapy modality was not appropriate for client's needs</li> <li>• Client had unrealistic expectations for change</li> <li>• Client did not "comply" with therapy</li> <li>• Rupture in T-C relationship</li> <li>• Fault of therapist; Inadequate training of the therapist</li> <li>• Factors external to therapy (including client's environmental system); Presenting problem difficult to treat</li> <li>• Premature termination; Insufficient # of sessions possible</li> </ul>
<b>Client</b>	<ul style="list-style-type: none"> <li>• T-C relationship; Too many/few sessions</li> <li>• Non-specific factors</li> <li>• Therapist not effective; Therapist unskilled</li> <li>• Therapist did not pace with client</li> <li>• Therapist did not understand</li> <li>• Therapeutic approach not comfortable/did not fit</li> <li>• System in which therapist works presented stumbling blocks</li> <li>• Client's own environmental system presented barriers</li> <li>• Therapist had different goals than client</li> <li>• T &amp; C had different etiological understanding</li> <li>• Therapist did not listen well; Rupture in T-C alliance</li> </ul>

**Table 1-5**

**Bracketing the personal impact of successful therapy**

<b>PERSPECTIVE</b>	<b>ASSUMPTIONS, BIASES, HYPOTHESES</b>
<b>Therapist</b>	<ul style="list-style-type: none"><li>• Reinforces therapist's sense of professional efficacy</li><li>• Enhances therapist's ego</li><li>• Enhances degree to which work is experienced as meaningful</li><li>• Reinforces adherence to particular modality/orientation</li></ul>
<b>Client</b>	<ul style="list-style-type: none"><li>• See Client's Definition (Table 1-1)</li></ul>



**Table 1-6**

**Bracketing the personal impact of unsuccessful therapy**

PERSPECTIVE	ASSUMPTIONS, BIASES, HYPOTHESES
<p><b>Therapist</b></p>	<ul style="list-style-type: none"> <li>• Decreased self-efficacy</li> <li>• Blame the client; Blame self</li> <li>• Reinforce “bad client” construction</li> <li>• Acceptance of the reality of unsuccessful therapy</li> <li>• Loss of revenue due to marred reputation</li> <li>• Question meaningfulness of work</li> <li>• Question interpersonal skills</li> <li>• Question own abilities; Question analytical skills</li> <li>• Question efficacy of modality</li> <li>• Question “where did I go wrong”</li> <li>• Reputation (in and out of professional community)</li> <li>• Question elements of the system in which the therapist works</li> </ul>
<p><b>Client</b></p>	<ul style="list-style-type: none"> <li>• Increased frustration with presenting problem</li> <li>• Increased helplessness; Self-blame</li> <li>• Skepticism/reluctance about future therapy</li> <li>• Globalizations about efficacy of therapy</li> <li>• Ramifications on environmental system</li> <li>• Lack of respect for therapist/profession</li> <li>• Seek other therapist; Seek other modality</li> <li>• Give up/lose hope; Get revenge</li> </ul>

With respect to how therapists and clients might define successful and unsuccessful therapy, and consistent with a consumer-oriented stance, I believe that both therapists and clients put a lot of stock in whether or not positive change resulted from the therapeutic encounter. I suspect that clients might also define therapy as unsuccessful when they perceive that the costs of therapy (e.g., time, energy, financial expense) exceed whatever benefits (e.g., positive change) they derive from it. Further, I believe that clients might define therapy as unsuccessful when they have a negative experience of the therapist-client relationship.

With respect to attributions about what is responsible for successful and unsuccessful therapy, I believe that both therapists and clients might point to themselves, each other, and the 'fit' between them. However, specific to unsuccessful therapy, I believe that 'finger-pointing' (i.e., the therapist blames the client, and the client blames the therapist) is more common than self-blame, for both therapists and clients. Further, I believe that the language of many theories of psychological therapy promotes that therapists assume a client-blaming stance. When we (as therapists) describe clients as 'resistant,' 'noncompliant,' or as 'premature terminators,' we are demonstrating, in my opinion, a tendency to shift the spotlight of blame away from the therapist and onto the client.

With respect to the personal impact of successful therapy, I believe that therapists experience such outcomes as gratifying in both personal (i.e., internal, or psychological) and professional ways. On the other hand, I believe that for clients, the personal impact of successful therapy is fundamentally synonymous with their definition of successful therapy: an experience or encounter that brings about positive, desired

change in their lives. In terms of unsuccessful therapy, I believe that for both therapists and clients, this undesirable manifestation of the helping process has the potential to exact profound and devastating consequences. For therapists, unsuccessful therapy experiences likely produce significant thoughts and feelings of self-doubt, thereby shaking up the therapist's self-efficacy. Similarly, for clients, who enter therapy already in some degree of distress, I believe that unsuccessful therapy experiences exacerbate their state of crisis or despair. Taking again a consumer-oriented stance, I assume that when clients have unsuccessful therapy experiences they become more skeptical of the therapy 'product.' Consequently, there is a risk that clients will turn away not only from the failed course of therapy, but also from the enterprise of therapy.

Importantly, the process of bracketing my assumptions, biases, and hypotheses was not limited to an exercise conducted at the front-end of the study. As I progressed through all stages of preparation, interviewing, analysis, and the writing of the final theory, I continued to bracket my unfolding understanding of the content area by logging thoughts, feelings, and experiences in a research journal. The entirety of that log will be presented later, in Chapter Three.

## **CHAPTER TWO:**

### **GROUNDED THEORY METHODOLOGY**

#### **2.1 The Choice of Methodology**

Although this study did not begin with my being wedded to a predetermined, specific research question (a discussion of this feature will be presented later), it was predicated upon a clearly articulated, yet broad in scope, content area: clients' experiences of unsuccessful psychotherapy. Many different research methods could have been chosen to investigate this realm of experience, spanning both the quantitative and qualitative domains. However, since I am interested in clients' subjective experiences, and desired to create a product that is rich with their voices, I eliminated quantitative approaches from consideration. Within the qualitative domain, approaches that might have been appropriate to my purposes included phenomenology, ethnomethodology, and grounded theory methodology.

My choice of Glaser and Strauss's (1967) grounded theory methodology, versus one of the other equally acceptable and established qualitative approaches, had much to do with the 'fit' between qualities of the methodology and qualities of me as a researcher. The grounded theory methodology is rigorously systematic, much more than either phenomenological or ethnomethodological methods are, which is a quality that is both appealing to and complemented by my personality and general approach to life tasks (including research).

Glaser and Strauss's (1967) grounded theory methodology is also more suited to researchers who are interested in generating findings, or theories, that are directly tied to (or grounded in) the data. This quality has particular appeal to me at this stage of my research career because, as described earlier, I have had concerns about the degree to which elements of myself have found their way into the research product. Although the grounded theory approach does not prevent biases and assumptions of the researcher from colouring or shaping the final product, the systematic design of the methodology does create more opportunity for the researcher to monitor, to become aware of, and to reveal to the audience such influences.

The methodology and rationale for grounded theory are historically grounded in the seminal work of Glaser and Strauss (1967): *The discovery of grounded theory*. Although Strauss and his colleagues have subsequently produced what have become more widely-cited versions (e.g., Strauss & Corbin, 1990; Strauss & Corbin, 1998), I relied exclusively upon the methodology propounded by Glaser and Strauss (and further clarified by Glaser, 1992, in a rebuttal to Strauss & Corbin, 1990) in the current study.<sup>2</sup>

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<sup>2</sup>Rennie (1998a) conducted a critical comparison of the internal philosophical and logical consistency of Glaser's (1992) construction of grounded theory (which is in keeping with Glaser and Strauss, 1967) with that of Strauss and Corbin (1990). Rennie concluded that Glaser's construction can be shown to be "coherent with its stated objectives" (p. 115), whereas that of Strauss and Corbin can not (see also Rennie 1998b).

Glaser and Strauss (1967) presented a methodology for discovering theory from data that was in sharp contrast to the then (and still) dominant research methodology in psychology that strives to determine the extent to which data can rigorously test and, in a Popperian sense, falsify theories. A grounded theory approach, therefore, is predominantly predicated upon the use of inductive rather than hypothetico-deductive (or verificational) research strategies. Glaser and Strauss stated that the adequacy of the generated theory, derived from data, cannot be separated from the process undertaken to create it. The process of theory generation must be systematic at every step of the way, including data collection and analysis. Glaser (1992) described the grounded theory approach as:

a general methodology of analysis linked with data collection that uses a systematically applied set of methods to generate an inductive theory about a substantive area. The research product constitutes a theoretical formulation or integrated set of conceptual hypotheses about the substantive area under study . . . . Testing or verificational work on or with the theory is left to others interested in these types of research endeavors. (p. 16)

Although I found the writings of Glaser and Strauss intriguing, compelling, and even inspiring, a problem with respect to the logic of justification of the grounded theory methodology became apparent to me upon closer inspection. Some of the language used by Glaser and Strauss took me aback, because it seemed to imply a leaning toward realist or positivist philosophical underpinnings. For example, they suggested that the

role of the investigator is to “discover” a theory that will “emerge” from the data. At the same time, Glaser and Strauss implied a relativist position by acknowledging that different analysts who are working with the same data set may produce different theories. If, indeed, the grounded theory methodology positions the researcher to “uncover” some “objective truth,” and mandates the researcher to assume an objectivistic stance, then it brings into question the degree to which this methodology was compatible with my philosophical assumptions (see Section 1.3.2).

I could not find in the writings of Glaser and Strauss (1967) any reconciliation of the seemingly incompatible philosophical positions of realism and relativism (see also Madill, Jordan, & Shirley, 2000). This left me feeling not only confused, but uncomfortable, because I believe it is necessary for a researcher to be clear about the philosophical underpinnings of the chosen methodology, or the logic of justification of the inquiry, as well as to be sure that such philosophical positions are in keeping with his or her own beliefs. Learning that I was not alone with respect to my confusion and concern was somewhat comforting. Rennie (1995b) has stated that, relative to his experience of adapting the grounded theory methodology to psychotherapy research,

gaining a clear sense of the logic of justification has proved more difficult. . . .

This aspect of the qualitative approach strikes at the heart of the philosophy of social science and, to complicate matters, currently is deeply contextualized within the sociology of this science. (p. 199)

Rennie (1998a, 2000) subsequently took on the intellectually challenging (and, indeed, intimidating) task of deconstructing the grounded theory methodology, in an effort to reconcile the inherent tension between relativism and realism, and to produce a new logic of justification for the grounded theory method. Following from his contention that the writings of neither Glaser nor Strauss have successfully accomplished this (see also Cupchik, 2001), Rennie argued that when we understand the grounded theory methodology within the larger framework of his reworked ‘methodical hermeneutics’ (“a union of hermeneutics and method,” Rennie, 2000, p. 482), we can reconcile the tension between relativism and realism with both the subject matter and the procedures of the grounded theory method.<sup>3</sup>

Rennie (2000) argued for methodical hermeneutics as an appropriate logic of justification for the grounded theory methodology by first establishing that the methodology does, indeed, have a hermeneutic nature. Rennie suggested that hermeneutics may be defined as the theory of the operation of understanding in its relation to the interpretation of text (see Ricoeur, 1981). Further, he suggested that researchers may interpret texts at various depths. When it is the latent meaning of texts that is interpreted, relativity is heightened, whereas when it is the manifest meaning that is interpreted, objectivity is enhanced. The use of bracketing techniques or, more

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<sup>3</sup>Rennie (2000) clarifies that his essay should not be considered as a “final accomplishment” of the reconciliation of realism and relativism, in the context of the grounded theory methodology, but rather that it represents a contribution in pursuit of such an accomplishment.



generally, a reflexive stance, further enhances objectivity in the grounded theory methodology. Rennie (2000; see also Annells, 1996; Kockelmans, 2002; and Rennie, 1999) suggested that methodical hermeneutics, therefore:

maintains that a relativized version of Husserl's technique of bracketing offers a middle ground between realism and relativism so long as the investigator makes a conscientious effort to be self-reflective and to express the returns from the reflexivity. (p. 495)

Rennie (2000) challenges Glaser and Strauss's (1967) claim that the nature of the inductive processes alone, prescribed by their method, can establish the validity of the categories (and, hence, the theory) produced through a grounded theory methodology. Instead, he draws upon Peirce's Theory of Inference (see Peirce, 1965), which posits that new knowledge is generated through the interactive inferential processes of induction and abduction, the latter of which we can define as the "imaginative creation of a hypothesis" (p. 489). Rennie substantiates the inherent validity of the categories produced through a grounded theory analysis given the self-correcting nature of induction that, according to Peirce, "involves the gathering of facts (induction), which give rise to an abduction, which is then tested by further induction" (p. 490). Taking together the objectivity-enhancing nature of reflexivity with the self-correcting and validity-enhancing nature of the intertwined processes of induction and abduction, Rennie (2000) argued that returns from grounded theory investigations are able to make 'knowledge claims,' consistent with a Cartesian-Kantian epistemology.

Rennie (2000) suggested that it is his blend of this Cartesian-Kantian epistemology with both hermeneutics and rhetoric (as described in Section 1.3.1) that distinguishes his articulation of methodical hermeneutics from previous offerings. More importantly, Rennie's articulation of methodical hermeneutics provides an internally consistent logic of justification for the grounded theory methodology, which serves to relieve the tension between realism and relativism. Rennie concluded that:

the grounded theory method is very different from the positivistic approach to social science because it takes into account the double hermeneutic inherently constituting it. Accordingly, users of the grounded theory method need to resist a slide into the kind of objectivism that positivism upholds because this slide risks throwing the baby out with the bath-water. The 'life' of the subject matter is in the meaning of the text constituting it, and ascertaining the meaning is a matter of interpretation, which is always relative to the interpreter. Thus, in grounded theory analysis, the demonstration involved does not entail the deductive type so prized in natural science. Instead, as indicated, it involves the interplay between induction and abduction conducted reflexively. It also draws upon the assumption that the meaning of the text that is brought to light through the

grounded theory inquiry will resonate with an audience sharing a culture with the interpreter, such that the audience will identify with the interpretation and be moved by it. (p. 494)

As stated previously, the goal of the current study was to construct a theory of clients' experiences of unsuccessful psychotherapy. The theory must be grounded in the data and the phenomenon, and will necessarily be a relativized interpretation of clients' experiences. At the same time, relying on the logic of justification provided by Rennie's (1998a, 2000) methodical hermeneutics, the grounded theory method will allow me to make claims with respect to the validity of the knowledge claims that I ultimately put forward. My goal does not include engaging in verificational work; that task will be left for other studies, and to other researchers.

## **2.2 Designing a Grounded Theory Study**

The formative stage of this research, conceptualizing a grounded theory study, provided me with significant challenges and frustrations. Glaser (1992) stated that the researcher must fight the need to preconceive a research question, and "learn not to know, when telling himself or others what he is studying" (p. 24). While I am convinced that his strongly stated and somewhat radical perspective is completely consistent with and necessitated by an inductive approach of theory-generation, I was less certain how well a dissertation committee would receive a student proclaiming, "I do not know what I am studying." I recognize my fortune in having a trusting, well-informed, and open-minded group of individuals on my advisory committee.

According to Glaser (1992), the researcher (and, perhaps, the doctoral candidate's committee) can rest at ease because adherence to the methodology will flesh out the emergent problem, or the research question. Instead of relying upon a research question that is based on a statement that decisively identifies the phenomenon in question, the research problem in a grounded theory study emerges from the data analysis. The questions about the problem that emerge through data collection and analysis, then, guide the direction of subsequent data collection (a process that Glaser has termed, 'theoretical sampling'). With respect to the initial conceptualization of the grounded theory study, Glaser offered the following reassurance:

The grounded theory researcher bypasses [the] problem in getting started by simply studying what is to be studied with no preconception of what should be in advance of its emergence. He has the patience and security and trust to wait for its emergence. Also he trusts himself not to know in advance and forces himself not to pontificate that he knows better than the subjects involved what is most relevant to them. (pp. 25-26)

Adhering to the Glaserian methodological stance, I asserted in my research proposal only that I would investigate clients' experiences of unsuccessful psychotherapy using a grounded theory methodology. I did not offer an articulation of a particular research question, for I was cautiously confident that the research problem would emerge through the collection and analysis of the data. Moreover, I did not begin by conducting a prestudy review of the literature because doing so at the formative stage

of the research process is simply not consistent with the grounded theory methodology. Glaser (1992, p. 31) stated unequivocally that “the dictum in grounded theory research is: There is a need *not* to review any of the literature in the substantive area under study” (emphasis added). Elsewhere, Glaser (1978) has explained that the researcher must:

enter the research setting with as few predetermined ideas as possible – especially logically deduced, a priori hypotheses. In this posture, the analyst is able to remain sensitive to the data by being able to record events and detect happenings without first having them filtered through and squared with pre-existing hypotheses and biases. His mandate is to remain open to what is actually happening. (pp. 2-3)

This position does not mean that the existing contributions in various literatures (either directly or indirectly related to clients’ experiences of unsuccessful psychotherapy) are neither valued nor useful in this or any other study utilizing a grounded theory methodology. Such contributions may be useful, but only at later stages of the research process. Markedly distinct from traditional deductive approaches, Glaser clarifies that in an inductive study, at such time as the researcher sufficiently develops the theory (and, of course, grounds it in the data), he or she should then utilize the literature to whatever extent necessary. The purpose of the literature use at the end stage of the research is to relate the theory to it “through integration of ideas” (Glaser, 1992, p. 31). Glaser suggested that scheduling the use of various literatures after theory development is a more efficient approach because the researcher can quickly access

material that is relevant to the research problem, which, as described earlier, he or she does not know at the beginning stages of the research process.

### **2.3 Data Collection and Analysis**

The grounded theory methodology demands that theory be generated from data in a systematic manner. Another crucial element of this methodology is that researchers systematically obtain the data themselves through social research practices (Glaser, 1978). Grounded theory procedures<sup>4</sup> have been designed to ensure that both data collection and analysis (which, importantly, are concurrent and covariant processes) proceed in a systematic, methodical fashion, with an end goal of generating theory that is grounded in the data.

Rennie, Phillips, and Quartaro (1988) stated that, at the earliest stages of data collection, the researcher's primary goal is to develop an understanding of what is most central to the phenomenon under investigation. The implication of this goal for initial data collection is that the researcher seeks participants who will likely be able to represent the phenomenon. Moreover, the researcher makes no effort during the initial phases to assemble a heterogeneous sample; instead, in the interest of promoting the emergence of (interpreted) commonalities among the participants, it is best, especially in

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<sup>4</sup> These procedures, originally scribed by Glaser and Strauss (1967), are outlined in a particularly clear fashion by Rennie, Phillips, and Quartaro (1988) and Rennie (1998a); it is these latter two sources that are relied upon in the current discussion.

the initial stage of the inquiry, to select a group of participants who appear homogeneous with respect to the phenomenon of interest.

In a discussion of the prudence of conducting either an open-ended or a structured form of inquiry in the research interviews, Rennie (1995b) suggested that the interview format should be open-ended in the early stages of data collection, and that this stance is consistent with that proposed by Glaser and Strauss (1967). The open-ended inquiry format is preferable, particularly in the early stages, because such an approach minimizes the likelihood that the interviewer will miss potentially relevant information held by the interviewee.

Also in keeping with the Glaser and Strauss (1967) exposition, Rennie (1995b) clarified that in the later stages (i.e., after the point at which some categories have emerged, and the process of conceptualization has begun) it is acceptable to pose more focused questions to interviewees. Moreover, both Rennie and Glaser and Strauss condoned introducing particular phenomena to the interviewee for discussion, but such a maneuver would only be consistent with the grounded theory methodology after the researcher widely experienced the particular phenomenon in the sample of participants. Thus, at all stages of data collection, there is a fundamental need to not force the data. As Glaser (1992) clarified, what the interview is about empirically must relate to and guide the interview questions, so that the interviewer not only does not force the data, but also maximizes the amount of non-forced data that she or he can acquire.

As Glaser (1992) pointed out, it is both the content of, and gaps in the theory, which begin to emerge over the course of data analysis, that point the researcher to the subsequent steps in data collection. Glaser and Strauss (1967) termed the purposeful

selection of additional sources of data, based on the emerging theory, theoretical sampling, and Rennie et al. (1998) has termed it theory-based data selection.

This sampling method contrasts sharply with the careful planning of data collection, which researchers need to meticulously prearrange in verification research methodologies. Glaser (1992, p. 101) defined theoretical sampling as “the process of data collection for generating theory whereby the analyst jointly collects, codes, and analyzes his data and decides what data to collect next and where to find them, in order to develop his theory as it emerges.” Although the minimum number of interviews required to generate a theory of clients’ experiences of unsuccessful psychotherapy was unknown to me at the outset of this research, I offered my committee my commitment to including no fewer than 10 participants in the study.<sup>5</sup>

Rennie et al. (1988) described the constant comparison method as an approach that researchers use when they

systematically categorize data and limit theorizing until patterns in the data emerge from the categorizing operation. This method requires data collection, open categorization, memoing, moving toward parsimony through the determination of a core category, recycling of earlier steps in terms of the core

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<sup>5</sup> McCracken (1988) stated that in qualitative studies, “it is more important to work longer, and with greater care, with a few people than more superficially with many of them. For many research projects, eight respondents will be perfectly sufficient” (p. 17).



category, sorting of memos, and the write-up of theory in terms of the picture arrived at through the last step. (p. 141)

Glaser and Strauss (1967) pointed to four 'stages' in the constant comparative method: (1) comparing incidents applicable to each category, (2) integrating categories and their properties, (3) delimiting the theory, and (4) writing the theory.

In the first stage, the researcher begins by coding the data into as many categories as possible. As Rennie (1998a) described, each datum is constantly and systemically compared to other data, and the overlap and categories represent similarities in the data. The researcher assigns each datum to as many categories as is possible and prudent. Glaser and Strauss suggested that coding (or categorizing) the data can take the form of making notes in the margins of transcripts, but may also be done more elaborately with separate reference cards or files.

Glaser and Strauss (1967) proposed a defining rule for this comparative method: "while coding an incident for a category, compare it with the previous incidents in the same and different groups coded in the same category" (p. 106). The constant comparative method should quickly yield the development of theoretical properties of the category (that is, a higher level of abstraction). The theoretical properties of the categories may include the "full range of types or continua of the category, its dimensions, the conditions under which it is pronounced or minimized, its major consequences, its relation to other categories, and its other properties" (p. 106). Glaser and Strauss predict that after the researcher has coded data for a particular category a handful of times, the analyst will experience conflicts in the emphases of her thinking. It

is at such times, they suggested, that the analyst should stop and write a memo of these thoughts, a process referred to as theoretical memoing.

In the second stage, the units that the researcher is constantly comparing change from ‘incident with incident’ to ‘incident with properties of the category.’ This development sets the stage for the integration of categories with other categories, as the researcher is comparing incidents and properties, and such integration necessitates the analyst to make theoretical sense of each subsequent comparison. Hence, the theory begins to emerge from the data.

In the third stage, the theory begins to solidify through the strength provided by new data and the associated comparisons. The major theoretical modifications, which are a regular occurrence in stages one and two, become less frequent as the researcher makes comparisons between incidents and properties and categories. Minor theoretical modifications include clarification of logic, removal of irrelevant properties of categories, and overall reduction in the number of categories and properties.

During the third stage of the constant comparison method, the researcher can formulate the theory with a smaller number of higher order concepts, making it more parsimonious. Theoretical modifications resulting from comparison of the elements (i.e., categories, properties, etc.) to the literature of related content areas, during the third stage, can also enhance the scope of the theory. Also during this stage, the analyst becomes aware that the categories have become theoretically saturated: The analyst does not need to code new data when comparison of them to the theory reveals that he or she has attained nothing new.

The fourth stage of the constant comparison method is writing the theory, which, of course, is the primary goal of the entire study. When the researcher has reached this final stage, coded data, theoretical memos, and a developed theory will all be available. The analyst can organize the memos by category, to facilitate the coherent organization of the theoretical description, and provide a direct link to coded data, which he or she can use to validate and illustrate elements of the theory. Glaser and Strauss (1967) suggested that the memos provide the “content behind the categories, which become the major themes of the theory later presented in papers or books” (p. 113).

#### **2.4 Evaluating the Merits of the Theory**

According to Glaser (1992), a grounded theory has merit when it meets two leading principles associated with solid, scientifically-induced theory. The theory must be parsimonious while still having sufficient scope; it must account for as much behavioural variability as possible with as few theoretical elements as possible. Further, a grounded theory that is well constructed will meet four central criteria: fit, work, relevance, and modifiability.

*Fit* refers to the consonance between the grounded theory and the phenomenon as understood by the participants and other researchers in the content area. *Work* refers to the ability of the theory to explain the major variations of behaviour in the content area, in the context of the primary concerns expressed by the participants. *Relevance* of the theory is achieved when it both fits and works. Finally, Glaser advocates that the theory not be ‘written in stone’ and should be *modifiable*, to accommodate new data that suggest a need for variations in the structure of the theory.

Later, in Chapter Five, I present an “Exercise in Self-Scrutiny,” which includes my evaluation of how successfully the theory that I produced through this research meets Glaser’s principles and criteria.

## **CHAPTER THREE:**

### **GROUNDED THEORY METHOD**

#### **3.1 Method as Practiced Methodology**

When writing up my undergraduate honours thesis research, my supervisor corrected my ill-informed use of the terms ‘method’ and ‘methodology.’ I came to understand that the terms are not interchangeable, and that I am not to randomly substitute the term methodology for method. My interest in avoiding repetitive language and, perhaps, my effort to write with sophisticated style likely motivated such misguided substitutions. However, I still did not truly understand the implications of the distinction between these two terms, to which my supervisor was attempting to draw my attention. My ignorance in this respect is now, I hope, much less than it once was. I have come to understand the methodology-method distinction as analogous to the distinction between ‘creeds’ and ‘deeds.’

The previous chapter presented the creed, or underlying philosophy and logic of justification that gave rise to the deeds I performed in conducting this study. The creed, or grounded theory methodology, prescribes, delimits, and substantiates the way of doing business, with respect to the current study. I endeavored to have my research deeds, or methods, be as similar to that which the methodology suggests. However, the translation and transformation of conceptual methodology into practiced method are

neither simple nor easy processes, just as the application of psychological theory to clinical practice is neither an absolute nor exact undertaking.

Although it is reasonable to expect some deviations between the method employed and the method prescribed by the methodology, such deviations require careful scrutiny. It is for this reason that I have chosen to present the methodology and method in separate chapters, and to highlight the deviations in actual method of which I am aware. Consumers of research must have such information presented to them explicitly if they are to be able to make informed and valid interpretations of the returns of research. It appears that the qualitative research literature more explicitly advocates evaluations and disclosures of discrepancies between the methodologically-prescribed method and the practiced method, in comparison to the quantitative research literature. The reasons for such underemphasis in the latter realm remains somewhat of a mystery to me, but they do not appear to be predicated upon philosophical or logical grounds.

## **3.2 The Participants**

### **3.2.1 Recruitment**

In the current study, I published an advertisement in the *Saskatoon Star-Phoenix* (see Appendix A), a daily newspaper, in an effort to seek out individuals who have had unsuccessful therapy or counseling experiences who would be willing to participate in research interviews. I received responses from 18 individuals. When I contacted each of the respondents by phone, I used a standard script (see Appendix B) to evaluate the suitability of each individual, within the context of two inclusion and two exclusion criteria.

To be eligible to participate in the study, volunteers needed to have had a personal unsuccessful experience with talk therapy. During the telephone screening protocol, I stayed alert to detect the presence of current crisis, and in such cases I was prepared to make appropriate referrals to a community mental health agency, if deemed necessary and appropriate. I also wanted to screen out volunteers who reported that their unsuccessful psychotherapy experience related to a current course of therapy, due to concerns that the research process would interfere with an ongoing therapy process. These two exclusionary criteria were predicated upon ethical considerations.

A total of 18 individuals responded, including one individual who responded by letter because he did not have a phone. Four of these individuals did not return follow-up phone messages. I disqualified three additional individuals because they did not meet the inclusion criterion of having personally experienced unsuccessful therapy. Thus, of the total respondent group, I deemed 11 appropriate for participation in the study, each of whom I subsequently interviewed.

### **3.2.2. The Interviewees**

I did not ask participants to provide me with detailed demographic information. For the purposes of describing the sample, such that readers would be able to adjudicate the applicability of the resulting theory to their own situations, I was able to glean sufficient participant information from my observations and the contents of the interviews. Types of information gathered included sex, ethnicity, estimated age, number of therapy experiences, types of practitioners, presenting problems, and the presence (or absence) of past or present gross psychopathology.

Of the 11 participants, 6 were women, 9 were Caucasian, and 2 were members of the First Nations community. The group of interviewees appeared to range in age from early 20s to early 60s, and I estimated that the median age was approximately 40 years. During the interviews, all participants reported histories that included multiple therapy experiences. Practitioners from whom the participants sought help included psychologists, psychiatrists, social workers, and counsellors with unspecified training. Participants did not specifically report the theoretical orientations of any of their therapists. Presenting problems reported by participants included depression, anxiety, marital difficulties, parenting difficulties, bereavement, addictions, adjustment difficulties, pain management, and eating disorders. Participants neither demonstrated nor reported during the interviews any history of psychotic symptoms.

### **3.3 The Data**

#### **3.3.1 Interviews**

I conducted interviews at the Psychological Services Centre at the University of Saskatchewan. I discussed matters of participants' freedom to withdraw, confidentiality of information, and limits to confidentiality with each participant prior to the interview. I documented volunteers' consent to participate on a Consent to Participate form (see Appendix C), a copy of which I provided to the volunteer. I asked participants to describe their experiences of unsuccessful therapy or counseling, but I did not require them to make any comments or answer any questions with which they were not



comfortable. I audio taped all interviews, which each lasted between one and two hours in length, and then transcribed<sup>6</sup> the tapes.

I was very cognizant of the types of questions I asked of participants, paying attention to the particular stage of research and theoretical development at which I was operating at any given time. In the earlier interviews, I made a concerted effort to keep the interview format as open-ended as possible and facilitated interviewees shaping the content and guiding the direction of the interviews. Interviews began with a primary-level prompt, such as, “Tell me about your unsuccessful therapy experience.” Prior to commencing with the interview stage of the research, I also constructed a few secondary-level prompts for me to use in the event that interviewees required a modest enhancement in the degree of directiveness of the prompt. However, I found that I did not require the secondary-level prompts. Primary- and secondary-level prompts are presented in Table 3-1.

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<sup>6</sup> Although I audio taped and transcribed all research interviews, these two research procedures are not absolutely necessary in a grounded theory methodology. Some, like Glaser, prefer to make post-interview notes from memory.

**Table 3-1**

**Primary- and secondary-level prompts used in research interviews**

LEVEL	PROMPT
<b>Primary</b>	<ul style="list-style-type: none"> <li>• Tell me about your unsuccessful therapy experience</li> <li>• Tell me what you thought when you saw the ad in the paper</li> <li>• Tell me what prompted you to call me</li> <li>• You may define “unsuccessful” in any way that fits for you</li> </ul>
<b>Secondary</b>	<ul style="list-style-type: none"> <li>• Tell me what made your therapy experience unsuccessful</li> <li>• Tell me about why you think your therapy ended up unsuccessful</li> <li>• Tell me what impact this unsuccessful therapy experience has had on your life</li> <li>• Tell me what it means for you to have had an unsuccessful therapy experience</li> <li>• Tell me what would have made your therapy experience more successful</li> </ul>

### 3.3.2 Transcripts

I used codes (e.g., C1, C2, and so on) to represent the names of participants when making reference to any quoted material from the transcripts. Thus, it is highly unlikely that the anonymity of participants in this study could become compromised through the use of direct quotations in the final product of this research. However, to ensure that participants were consenting to the use of their material in a fully informed manner, and to ensure the accuracy of the transcript material, I gave participants the opportunity to review the final transcript and I invited them to modify or withdraw any or all of their responses. I then requested participants to sign a “Data/Transcript Release Form” (see Appendix D) wherein they acknowledged by their signature that the transcript accurately reflected what they said or had intended to say, and that they agreed to have their transcript used in this study, including potential use of direct quotes. All participants offered their consent.

I gave participants the opportunity to provide their mailing addresses if they wished to have a summary of the study sent to them upon its completion. I also invited them to provide feedback based on their review of this summary<sup>7</sup>. Importantly, to stay true to the philosophical and methodological underpinnings of a grounded theory methodology, there was no intention to use any feedback derived from participants as a verification strategy to ‘test’ the theory that I would later develop. Instead, there is the potential for me to use such feedback as yet another source of information with which to

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<sup>7</sup> A condensed version of the theory was sent to each of the nine participants who provided their mailing addresses, along with a restated invitation to provide feedback either in writing or by phone. No responses were received.

evaluate the degree to which the theory fits, works, and is relevant. Inviting participant feedback has had a second, equally necessary and essential purpose: To demonstrate my respect for the knowledge, wisdom, and commitment of these volunteers. I believe it is critical that, as researchers, we actively demonstrate the indispensable value that participants bring to our investigations.

I transcribed audio tapes of the research interviews. My transcription experience in the current research project affirmed the value I place on performing this tedious work myself, rather than ‘contracting out.’ Transcribing research interviews allows the investigator to become intimately familiar with, and to stay close to, the data (see Rennie, 2000). For example, each interview required approximately ten hours of being fully immersed in the data set to accomplish the transcription. Transcribing provided me with the opportunity to hear the voices of participants for a second time. Different from in the actual interview, though, transcribing required only that I listen to the conversation, rather than actively participating in it. From that somewhat more detached, ‘fly on the wall’ perspective, I was able to pay very close attention to the essence of what I was hearing.

On a more technical but equally important level, as I transcribed each interview, I was able to ensure that the product was accurate, in terms of being a valid representation of the interview conversation. Often in this type of work, a detached transcriber submits the product to the original interviewer who then comments on its accuracy. In the process described here, I efficiently combined these steps into one. Further, I was able to “smooth” the text (i.e., remove meaningless false starts, redundancies, superfluous ah’s and umm’s, etc.) as I transcribed, which resulted in a

much ‘cleaner’ product and was still appropriate within the bounds of the chosen methodology (see Mishler, 1991).

### **3.3.3 Meaning Units**

I broke each transcript into ‘meaning units,’ each of which constituted one datum for me to use in the constant comparative method. Meaning units were approximately one paragraph of textual material in length and represented a particular idea that the interviewee was conveying. The process of breaking transcripts into meaning units not only requires the analyst to segment the data set, but also requires her or him to decide what material should be kept and, perhaps more important, what material he or she should discard.

Although the practice of ‘throwing away’ data may seem circumspect to some, there are elements of any conversation that are simply not germane to the research content area (e.g., interactions with participants at the beginning of interviews focusing upon the purpose/scope of the interview; irrelevant tangents that interviewees occasionally embarked upon, such as the recent collapse of a chicken farm; etc.). The number of meaning units in each transcript ranged from 22 to 98, averaging 60 meaning units per transcript, and a total data set of 593 meaning units.

## **3.4 The Research Process Journal**

The grounded theory methodology promotes the use of theoretical memos to allow the researcher to monitor her or his thoughts, feelings, biases, hunches, doubts, and so on that surface and that he or she actively identifies throughout the research

process. In the current study, I kept two distinct journals: one focused upon the content of the emerging theory, and the other focused upon the research process. Entries from the content journal formed the basis of the theory that is presented in the next chapter. I offer entries from my research process journal in this section in order to document some of the salient issues that arose as I translated, or transformed, the conceptual grounded theory methodology into an applied grounded theory method.

I debated about what type or amount of research process journal material was appropriate to present in a formal chapter of a dissertation. Certainly, an option existed to include such material in an appendix. My decision to present the material here was twofold: First, the issues presented here are germane to the methodological-method distinction and, as such, are central to the reader's critique of the quality of the research conducted. I do not believe that they deserve to be dismissed or relegated to an ancillary position in the presentation. The current presentation is also consistent with Rennie's (1995a) call for researchers to be forthcoming with the returns from their reflexivity.

Second, although such journal entries (usually referred to as 'memos') form a fundamental component of the grounded theory method, and the grounded theory methodology substantiates their use, it is rare for researchers to offer to others a glimpse into such a document. I would have benefitted from reading another researcher's journal prior to embarking on the current research project, for it would have allowed me to understand the types of issues, with which one grapples, that are inherent in conducting this type of study. Such an understanding would have been most validating and, in turn, reassuring.

The following entries from my research process journal are presented chronologically, and have not been significantly or meaningfully altered from their original form and content (save for grammatical and syntactical corrections). Readers can have confidence that I have included all entries of any substance, and I have made no attempt to selectively exclude entries. Taken together, these entries provide a comprehensive account of, and a window into, my experience of producing and carrying out grounded theory procedures, while staying vigilant of and true to the grounded theory methodology. I believe that this section of the dissertation helps to create a transparency of the research process, and demonstrates that I took a reflexive approach, both of which are not only helpful, but are in fact necessary, for an unimpeded and full critique of my work.

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I have now reviewed the first transcript, and have coded data to 24 categories. I am not clear what coding system(s)/family(ies) I have used in identifying these categories. Essentially, as I reviewed the data, I attempted to stay 'grounded' in them, and the question, "What are the data about?,"<sup>8</sup> guided me. In most cases, I coded a given datum to multiple categories, in an effort to preserve the richness of the data and to be careful not to force any one code on any one datum. Subjectively speaking, I do not believe that I was 'forcing' the identification/emergence of categories.

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<sup>8</sup> Rennie (personal communication, 2003) stated that he uses the slight different question, "What does the passage mean?"

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I am certainly experiencing the sense of ambiguity, for which the researcher must have tolerance. I also keep in mind Glaser's encouragement "to just do it," in the context of "learning" how to carry out a study predicated upon a grounded theory methodology.

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I am wondering about the next step. I could review the data coded at each category, compare them, and revise the category if appropriate. Alternatively, I could review the second transcript, likely find that the data indicate new categories, and then perform the comparative tasks that are integral to the grounded theory method. One difficulty with the practical application of the method is interpreting (and putting into practice) concepts such as "constant" comparison. Theoretically, the notion that coding and analysis are concurrent and covariant is enticing. However, one cannot ignore our (or, at least, my) inability to concurrently carry out these two tasks. In practice, and I believe our understanding of cognition would support this, we may quickly oscillate between competing tasks, but at any particular point are carrying out only one.

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In an effort to stay true to the need “to constantly compare” as consistently as possible, I will choose to follow the former path. Hopefully without falling into the trap of microanalysis (i.e., recognizing the need to keep my eyes on the ‘big picture’), I will review the data coded at each category, and determine if they indicate revisions to categories. Further, I will make (and elaborate upon) tentative connections between and among categories. With respect to category connections, I had been leery of identifying connections after reviewing only one transcript. I was thinking that “it’s too soon” and that I did not want to be “forcing” the emergence of the theoretical connections. However, upon further reflection, I recognize that in grounded theory methodology there is no need to keep comparisons at the ‘case’ level. Instead, comparison occurs at the level of the idea or, simply stated, two pieces of data (whether they are from the same or different ‘cases’).

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As I am writing this, I am concerned that I may have erred by not comparing each new datum with others already coded at a particular category. What consequences are there for coming back to the data at each category at natural points of pause (for example, upon completing review of a transcript)? Again, I think that this may be a matter of the frequency of oscillation between coding and analysis. Perhaps there is a

minimum frequency below which it would not be advisable (nor consistent with grounded theory methodology) to oscillate.

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I also need to slow the process down, perhaps, and ensure that I make appropriate memos with the emergence of each category. I suppose that the reason I have not done so, at this early stage, is twofold: (1) I cannot deny the sense of urgency I feel to “get on with it,” and (2) the categories that have emerged are not highly conceptual; hence, the tentative name that I have assigned to each category is very descriptive of the datum or data coded at it.

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I reviewed Dey’s<sup>9</sup> book again today, to assist me in clarifying my thinking about coding and categorization. I will proceed with identifying category ‘strings,’ because this metaphor seems to represent the ideal of concurrent and covariant coding and analysis and, additionally, seems to be more useful for developing a practical approach.

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<sup>9</sup>All references to “Dey” in this research process journal are to Dey (1999).

I need to give serious consideration to the ontological/epistemological issues regarding the role/activity/biases of the researcher in relation to the content of the theory that the investigator produces.

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In preparation for this research project, I investigated the potential utility of computer software programs, and came to understand that such tools have the potential to enhance the systematic nature and consistency with which the researcher manages the data. Enhancing these aspects of data analysis and management seems particularly desirable when working with a grounded theory methodology, which challenges the researcher to be as systematic and consistent as possible. I will use *NUD\*IST* (N5) software to assist me with the systematic, concurrent, and covariant processes of data management and analysis. N5 is designed for the storage, coding, retrieval, and analysis of text (Weitzman & Miles, 1995). The program does not perform any operations other than those the user instructs it to perform.

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After installing and dabbling with the N5 software program, I am now wondering about the implications of it permitting only a tree structure of categories, in terms of delimiting the range of possible ‘types’ of connections among categories. For example, isn’t it possible that we

could relate ‘children’ of one ‘node’ to their ‘cousins’? However, we could not represent this in a tree structure. Similarly, what about circular relationships among categories? Perhaps I will need to abandon the N5 software (and its limitation in this regard) once I can no longer represent the conceptualizing of category relationships in tree structure. I’ll defer this decision for now.

---

I’ve been thinking about the dictum of theoretical sampling within a grounded theory methodology, and how I employed theoretical sampling in this study. According to the method, participants (or groups of participants) should be selected on the basis of an emerging theory. In my study, participants were not selected on the basis of an emerging theory because I interviewed all participants who met the minimum criteria for participation in the study (i.e., all available participants) to ensure that I obtained the promised sample size of at least 10. However, I upheld the principle underlying theoretical sampling. After each interview, I wrote a memo to document the ideas and concepts that had emerged. After I completed the first few interviews, I identified certain similarities in the data, which indicated some higher-order concepts. I then asked the participants in subsequent interviews specifically for their thoughts/feelings/experiences surrounding these higher-order concepts.

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Thus, the emerging theory guided the data that I collected. The greater specificity regarding content in the last half of the interviews is consistent with Glaser & Strauss's description of how interviews should be, at first, very open-ended and the interviewer should not unduly guide or shape the direction of the interview. They condone, though, the interviewer using a more structured interviewing style at later stages of data collection. In this study, due to the "smallish" sample size, I started all interviews (even the last half) with the open-ended prompt: "Tell me about . . . ," because I wanted to ensure that I maximized collecting the most theoretically diverse set of data, which would thereby allow a maximally-rich theory to emerge. In the last half of interviews, I offered the more focused questions (based on the emerging theory/concepts) after participants had responded to the initial open-ended prompt.

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I have just finished reviewing the 11 transcripts again. Fascinating stuff! Really amazing how much people can and will tell you, if you simply invite them to (re Elliott and Kagan & Kagan - IPR - from my master's thesis). My next step is to rigorously evaluate how well I adhered to the model proposed by the grounded theory methodology, with respect to theoretical sampling and the co-occurring and covarying processes of data gathering and analyses. The steps I took in the research process, in this context, were:

1. Interview 1: review, make brief notes on where to go (topically) in next interview
2. Interview 2 and subsequent interviews: review, make brief notes, “recalibrate” (constant comparison) with respect to notes from the previous interview.

Then, in order to evaluate my methodical adherence, I:

1. Made new, detailed notes on the content of and concepts emerging from each interview
  2. Compared the emerging concepts from one interview to what I asked (per transcript) in the next interview
- 

The returns from this comparative analysis (see Table 5-3) indicate that my interview questions (data gathering “strategies”) were based upon and closely tied to the emerging concepts (data analysis). This provides one type of credibility check. However, it is also possible (probable?) that I will identify directions in which I “should” have gone in subsequent interviews, but did not. Can I avoid this dissatisfaction with a retrospective analysis of interview “performance?” Do “flaws” in interview direction necessarily represent a lack of theoretical saturation? I think not. Existing concepts could be saturated, but the range of concepts could be incomplete. What implications are there for such a restricted

range of concepts with respect to the theory that I generate? Does this mean the theory has limited (decreased) scope? On the other hand, it is neither reasonable nor possible to discern and explore “all” categories.

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Is it reasonable to have the precision/purity of the ideal method compromised or deviated from to a certain degree, to accommodate the pragmatic aspects of the research endeavour? For example, what about time limits with respect to the completion of interviews (i.e., data collection)? Glaser makes notes from memory after each interview. Does this approach give credibility to or legitimate my “deviations?” Is it sufficient to identify or disclose such deviations (similar to putting forward my own assumptions and biases)?

---

I am developing greater concerns about the suitability of the N5 software, as the (or even a) primary data analysis tool. I wonder what the risks are of losing sight of the forest through the trees by using the N5 software? I like keeping my eye on the “big picture” - which was how I approached my detailed review of each transcript and the related identification of concepts/categories in the data.

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Is there value in going through the data set now, with a “fine-toothed comb” via N5? Or, instead, can I essentially generate the theory by working with my notes? I think so. Here is the approach that I will take, in this respect:

1. Sequentially review notes from each interview, and work at the level of categories
2. Go back to my notes to derive category detail
3. Go back to the transcripts for examples and material to enrich the presentation of the theory.

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I have just gone through transcripts 1 to 6, and have successfully identified certain concepts and categories that seem to be emerging from the data, and that also have plausible utility in a theory of clients’ experiences of unsuccessful therapy. As I write this, I am now questioning the term “experiences” - does this encompass beliefs, feelings, expectations, etc? Is it too limiting? Did clients present to me more than “just” their experiences?

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I am wondering if I can create a more flowing narrative and integrated theory by using my notes to construct a running narrative, rather than focusing on discrete (and, perhaps, prematurely developed) categories.



Perhaps I would generate a more parsimonious theory in the above mentioned manner.

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I am now feeling quite frustrated with the process. I went ahead with the 'holistic'/big picture approach (i.e., I made notes about each transcript, then went through notes to identify categories, then worked with categories to identify relations, and attempted to allow the theory to emerge). Didn't seem to work. What I did, I think, was conduct a content or thematic analysis. This approach did not use the method of constant comparison. Big mistake. Consequently, no real 'theory' emerged, because categories were ill-defined and relations among them were difficult to discern while ensuring that I grounded those relations in the data. Essentially, I wound up seeing (through sketching out relations among categories) that clients make diverse attributions for their unsuccessful experiences, and then also identify the impact that such experience(s) has had on them in multiple contexts. Doesn't seem like much of a theory. I had to go back and think about the meaning of 'theory' and it seems that it should serve to explain patterns and variations in the data. What I just described (attributions & consequences) seems obvious, and entirely descriptive.

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Through whatever type of analysis I just completed, I also got the sense that the clients were experiencing a journey, or following some sort of path, from being novices to being more experienced clients. This seemed to have more of an explanatory thrust than the descriptive flavour of the attributions/consequences taxonomy. It will be interesting to see whether or not this concept of a journey is manifest in the theory that eventually emerges.

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I read through Dey, Rennie,<sup>10</sup> Stiles<sup>11</sup>, Turner,<sup>12</sup> etc. and I think I am back on track. Turner attempts to outline the steps of a grounded theory analysis in a (relatively) concrete manner. Rennie identified what features of a grounded theory study journal editors should evaluate, and this, too, provided guidance. Essentially, one of my mistakes was not coding meaning units to more than one category. Instead, I saw one meaning unit as belonging to one category (this is a hallmark of content analysis - see Rennie, Phillips, Quartaro). Whether that is what I did or not, the fact remains that I did not approach the task of data analysis in a sufficiently

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<sup>10</sup> References to “Rennie” in this research process journal are to a collection of writings by David L. Rennie, Ph.D., which are individually listed in the Reference section.

<sup>11</sup> All references to “Stiles” are to Stiles (1993) and Stiles (1995).

<sup>12</sup> All references to “Turner” in this research process journal are to Turner (1981).

organized and systematic manner, and one that is based on the grounded theory methodology. Hence, I am left confused about what the data mean, and the reader would not be able to sufficiently audit my work (re credibility, replicability, etc.) to consider alternative explanations.

---

I am going to start again. I have confirmed through a ‘credibility check’ that the data collection stage did, indeed, proceed in concert with data analysis. There was good correspondence between the ‘categories’ or ‘concepts’ that emerged from one interview, and the questions I asked in the next interview. I will also need to check - as I proceed with the new analysis - that the categories become saturated by the time I get to the final few interviews. That is, to check whether new categories are emerging from later interviews, which may indicate that I needed to collect further data to clarify these categories.

---

Now, I am going back to N5. A short while ago, I dismissed its use because of not being able to see the forest through the trees. I am less concerned about this, now, for two reasons. First, I have taken the time to holistically immerse myself in the data - albeit motivated by a misguided approach to data analysis. I now feel that I have a workable, more full understanding of the participants’ experiences, and am better informed

with respect to the content of the data (through my misguided content/thematic analysis). Second, I am going to set the meaning unit to be at the level of the paragraph (versus at the line or sentence level). This allows me to be working with more meaningful units of data, and I think makes less likely that I will miss the forest through the trees.

---

I need, now, to make notes about the suggestions provided by Turner, and the criteria for evaluating qualitative research suggested by Rennie. Turner described mechanisms for developing and saturating categories. He notes that theoretical saturation will occur at different stages for different categories. Although this is, perhaps, obvious, I am not sure that I had been recognizing the differential course of development that I should expect for each category. Turner went on to describe the process of abstracting definitions, and suggested that it is likely that through this process the researcher will discover the conflation of two distinct yet related phenomena within a single category. In such instances, the researcher needs to tease the phenomena apart. Turner also highlights Glaser's encouragement to write down ideas, insights, and links among categories before discussing them with colleagues. I am not clear, however, on the basis for this suggestion. Perhaps it follows from the idealistic objective of keeping the process of theory generation as closely tied to the data (versus other sources of information) as possible. Turner

suggested that at the later stages of theory generation, the researcher may find it helpful to sketch diagrams of links. This certainly fits with my style of thinking and learning.

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Further to my review of Rennie, Phillips, & Quartaro, I am satisfied that it is most appropriate, workable, and fitting with my style to break the transcript text in to meaning units, rather than analyze the material on a line-by-line basis, as Glaser suggested. I have always had concerns about the impact of decontextualizing data of any sort (i.e., regardless of whether the data are generated within research, clinical, or other contexts). I am somewhat undecided, though, about whether or not I should engage in the reductions of meaning units that Rennie proposed. Further to Turner's discussion of the theoretical saturation of categories, Rennie suggested that saturation often occurs after the researcher has analyzed between 5 and 10 transcripts.

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I am now going to modify my analytical course somewhat. I will break transcripts into meaning units, which means that I will determine what to keep, and - as importantly if not more so - what not to keep (an example of this would be my interactions with participants at the beginning of the interview, when we clarify the purpose/scope of the interview; another

example, some interviewees went off on tangents that were totally unrelated to the content area: e.g., about chicken farm collapse).

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Next, I will reduce the meaning units - in first-order fashion as described by Rennie (i.e., I will not decontextualize them, and I will preserve the meaning and language of the interviewees). Because the reduced form of each meaning unit will not be significantly different from the raw form found in the transcript, there should be no difficulty tracing the meaning unit back to the raw transcript so that excerpts from the interviewee can be located and presented in the manuscript to illustrate categories, properties, or relations among them. Each reduced meaning unit will constitute one paragraph, to allow me to import them into N5 intact. I will then use N5 to conduct open categorization of these meaning units, and will proceed accordingly from there with the later steps of the analysis.

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I just finished breaking the 11 transcripts into meaning units. I am not convinced that any further reduction (i.e., first-order reduction a la Rennie) is necessary. Upon reviewing Rennie's example, I do not see a conceptual or pragmatic difference between the raw meaning unit and the first-order reduction. Since the process of open categorization needs to be based on the raw transcript, there should be no concern about using the

raw meaning units, rather than reducing ones. At worst, I am sacrificing some convenience, or ease of working with the data. However, the use of N5 may compensate for this.

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I just finished coding the first interview. Seemed to go well, having adopted a 'true' grounded theory (constant comparison) approach. Should I now be looking at connections among categories? I think not. It's too soon. I need to develop the categories more fully, including revising the category names, if indicated by the data coded to them. I have been sticking to descriptive category titles, as suggested by Rennie, Dey, and Turner. In fact, I have been careful to use precise wording from the data. I want to avoid jargon at all costs, so that the resulting theory most closely represents the experiences and discourse of clients, rather than some externally imposed taxonomy or vocabulary. Also, I just reviewed Glaser's "six C's" - re coding families. I will keep this list handy when categorizing, to ensure that I am considering as many different 'types' of categories/relationships/codes as possible.

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I am now ready to start coding the second interview. In identifying category titles, I am not redundantly adding introductory phrases, such as, "C believes that . . .," "C perceives that . . .," as Rennie did. All of these

data are from C's, so such phrases do not add any useful information. Nonetheless, when making connections and articulating the final theory, the fact that all data came from the perspective of clients will be critical to identify. However, I will not state this as a limitation of the theory, since one of my goals was to create an understanding from the perspective of clients, and to provide a forum for us to hear their voices.

---

Coding of the second interview is now complete. Now what? Time to go back to Rennie, Glaser, and Dey to see what I need to do next. A manual would sure be nice! I am continuing to appreciate the need for a tolerance for ambiguity! Prior to reviewing these sources, I have a sense that I need to review the meaning units coded for each category, and review the category title to ensure that it is representative of the data. Also, I need to pay attention to (and memo) emerging relationships among the categories. Do I need to combine categories that are quite similar, or divide categories that appear to be representing more than one concept, at this stage?

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I am going to begin "browsing" the meaning units that I have coded at each category. Simultaneously, I am consulting the memo that I have been writing (while coding meaning units) for each category.



I just created some links among categories. I used a very conservative approach, in that I only linked categories that were, without much doubt, related. The three higher-order categories created were Communication, Expectations, and Ending. I have left most of the first-order categories unrelated for now, until I develop a clearer understanding of what each of them indicates.

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I just put the analytic machine in reverse, and have backed up! I just “liberated” all of the categories I had subsumed under the three higher-order categories mentioned above. I believed that I was prematurely linking these categories together, thus running the risk of creating a theory that I did not closely tie to the data, was thin, and lacking in complexity and sophistication. Yes, it would be nice to quickly link all the categories together, in terms of bringing some closure to the process. However, no pun intended, it would create “premature termination.” It seemed that I was linking categories using more of a thematic approach, than an inductive and abductive one that considers the many ways in which I may link the categories (e.g., Glaser’s 18 coding families).

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I now have 36 categories with which I am working. Somewhat unwieldy to manage. Any alternatives to this, or simply something with which I

must cope with for the time being, until higher-order patterns in the data emerge?

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I need to write ‘summary memos’ at the end of each ‘sitting’ of working with the data. The running memo contained herein was useful to reorient myself, but a concise summary of what I was thinking as I last left off - on a content rather than on a process level - would be very helpful as I jump back in after a short hiatus. This would allow some continuity of thinking. Such hiatuses are a naturally occurring part of the research process, when one spreads his or her time across competing activities - but present a challenge with which I must deal.

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I think that I have immersed myself in the data for a sufficient period of time. Mulling over the intricacies further, and avoiding experiencing the anxiety associated with the ambiguity of the analysis, is neither necessary nor prudent. Time to get on with it!

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I currently have 45 codes (a la N5: “free nodes”), among which I have not yet abducted relationships. I will review memos attached to each of these codes, and identify (oscillating between abduction and induction)

emerging descriptive categories, relationships among categories, and higher-order categories.

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Although I have flip-flopped over the course of the analysis about the appropriateness and utility of the N5 software, I have finally concluded that this software imposes certain limitations on the process of theory generation. The program affords users the ability to code, sort, and ultimately colligate meaning units from the data set, but the connections that users may make among meaning units (and, later, categories) must be linear, or hierarchical, in organization. I found this restriction to significantly limit the abductive process, and I have now chosen to abandon the use of the program at the later stages of theory generation. Nonetheless, N5 was found to be a handy and reliable data management tool for working with large volumes of textual data.

---

I have come up with 5 higher order categories: T-C Communication, Expectations, Ending, T-C Fit, and The Novice Client. The latter category has promise for being a core category, as - at this point - it appears to subsume the other higher-order categories.

---

Next step: I will subsume certain codes or descriptive categories under the five higher-order categories, as appropriate. I will write memos for each cluster of meaning units, for each “move.” I will take extreme caution to ensure that the emergence of either categories or the relationships among them is not being forced.

---

Note aside: I should revisit Finn’s conception (see Personality Assessment text) re challenging our interpretations, and arguing the opposite view. It seems this would be relevant to the processes of abduction and induction.

---

Several higher-order categories have emerged under a tentative core category of “The C’s Journey,” including: C’s expectations; making sense of problems in therapy; C-T communication; C-T fit; C as Novice; Multiple therapy experiences. Further induction is now necessary to move the analysis forward from this point, and thereby clarify the abductions that I have made. First, however, I will examine the dimensions and properties of these higher order categories, to ensure that I have clearly articulated my current understanding of the data (before working with more data).

---

I am beginning to experience the (negative) consequences of working with too many categories. It really is unmanageable at 55! Not only unwieldy, but also unnecessary. There is a creation of unnecessary/false heterogeneity in data that are actually more homogeneous.

---

It just occurred to me that I need not code every meaning unit from now on. I only need to code those meaning units that add to my understanding of the data and the categories, and that add richness and complexity to the emerging theory. I need not code those that merely reiterate already explicated aspects. I need to tidy up the current theory as it has emerged, so that I can efficiently identify whether a new meaning unit is worthy of coding.

---

I am wondering how might my biases about unsuccessful therapy influence the emergence of these categories? I just reviewed my bracketing statements, regarding my expectations for the client's and therapist's definitions of, impact of, attributions for successful and unsuccessful therapy. Interestingly, I do not recall even writing these characteristics down. I have immersed myself in the data for such a long time now (since writing down my expectations/bracketing) that the data are my reality! This is a good thing!

---

I clearly confused “codes” with “categories.” These pseudo-categories (i.e., codes) were found to be ‘empty’. There was no conceptual or even descriptive richness to them, because they essentially did nothing more than reiterate the content of the meaning unit (i.e., there was no integration among meaning units). Having one code for each meaning unit makes no gain.

---

I am continuing to try new technical strategies of doing the analysis that make it more efficient, and clear (to me). I think, at first, I was happily (and haphazardly?) assigning meaning units to various categories, because there was a prima facie fit. At that ‘stage’ of the analysis and the development of the theory, this was an appropriate strategy. I was ensuring that I was adding to the complexity and richness of the category development, to capture as many dimensions and properties of each category. At this stage, however, it is appropriate to assign meaning units to a category when it appears that the datum will add to the development of that category. Otherwise, I am dealing with redundant material. However, when a particular (newly encountered) meaning unit “captures” the essence of the category better than one previously coded to that category, but does not add to the conceptual development of that category, should I assign it still to that category, so that I can later offer

the verbatim comment of the particular participant as a prototype of the category?

---

The approach I am taking now is to compare newly encountered meaning units to the memo for each category to which I could assign it. This allows me to make a decision about whether the meaning unit adds anything to the conceptual development of the category. If it does, I assign it to the category, and I append the memo for that category; if it does not, I move on to the next meaning unit.

---

I have now worked through five transcripts. I am printing off the memo for each category. I think that it is important for me to see these thoughts on paper, and not just on the computer monitor. This way, I can literally hold one memo up next to another memo, and compare.

---

There is a real need to keep oscillating between the detail at the level of the meaning unit, and the 'big picture' of what clients are trying to say. This 'big picture' is, in essence, the theory itself. This oscillation does not occur without conscious effort, and integrating that movement into the analytic process.

---

I am beginning to see the forest through the trees! This, however, does not mean that I give up examining the trees in detail. Instead, I am starting to understand the forest in which the trees exist.

---

I have mapped out a tentative series of relationships among the higher-order categories (fit, acculturation, hopes for success, communication, changes, therapeutic failures). Now I'll work through the next few interviews. The Constant Comparative Method (aka abduction and induction) is a painstaking, labour-intensive, intellectually-challenging process. Nonetheless, it sure produces results that are grounded in the data.

---

Over night, I worried that the changes in my understanding of the data were indicative of flip-flopping, confusion, or impending doom. I have reframed this, however, and now understand these contrasting understandings as reflective of the abductive/inductive oscillation. Not to worry. Stay the course.

---

I am back after another (undesirable) hiatus. I am sure glad I have this journal/memo to consult upon my return. I'd be lost without it (and I



wonder what the implications would be for the ensuing analysis and theory that I ultimately produce).

---

I read several articles last night on the grounded theory methodology, and pitfalls therein. I think I am on the right track. I need to be careful to document the “comparing and contrasting” that I am doing, along with specific examples to illustrate this, in the process of identifying higher order categories (and even with respect to the properties of categories).

---

Many months have passed. After reading the entirety of my memos, I am convinced that the memoing process is absolutely central to the grounded theory methodology and, hence, the development of good theory. It is certainly, at least, crucial for efficiency. It’s time to wrap this project up. It really could continue indeterminably. Now, where to start, so that I can stop?

---

I zoomed out to the big picture, as I began immersing myself - yet again - in the data. I looked through my summaries of each of the 11 interviews, as well as through the memos of all categories that had emerged to date. I then identified the interrelationships among categories, and depicted this

graphically in a stream of consciousness manner. As I reviewed transcripts, summaries, memos, etc. I made notes on a large sheet of paper, and created a map of sorts. Central to this construction was the use of arrows to indicate directionality in terms of causally or temporally related attributes and categories. I was able to then work with this drawing, and determine what the essence of the data was. Metaphorically, I carefully examined the trees, and groves of trees, and then I stepped back and viewed and commented on the forest before me. The theory is readily emerging.

---

I am now becoming clearer about what the theory holds, and what it offers. I have articulated this in my memo on the Client's Journey. Aside from the content, and from a research process perspective, it seems essential to constantly (regularly, purposefully, intentionally) adjust the "zoom" on my analytic lens of focus on the data. This metaphor of the microscope is functionally appropriate and helpful, and perhaps is also consistent with the notion of "discovery." It also does not ignore the fact that I am using a hermeneutic lens through which my understanding of the data is influenced.

---

I have just finished going through transcript # 8 (again!), and I have noticed (I started noticing during my analysis of #7) that no new categories are emerging from the data. I am also noticing that new data coded to each category are not really clarifying my understanding of either the category in question or its relationships to other categories. So, I suppose this is what ‘theoretical saturation’ looks like. It’s really quite hard to identify or recognize a (relatively) abstract concept at the best of times, but even more so when you have never encountered the concept previously.

---

I am wondering about how I should (or shouldn’t) use the remaining data (interviews 9, 10, & 11), given that I have (apparently) achieved theoretical saturation. One option is certainly to set them aside, but I am reluctant to do so for two reasons. First, I made a commitment to my committee that I would interview at least 10 participants. Narrowly interpreted, I have done so. However, I think the real meaning behind this commitment was that I would analyze data from 10 participants (rather than meaning that I would sit down and talk with at least 10 people, and use some unspecified amount of the data). This is an example of a tension between what the methodology requires, or at least suggests, and how we put that methodology into practice (i.e., how it becomes the method). The second concern is that there may be certain data - quotes - in the

remaining transcripts, which provide better exemplars of the categories than the data currently coded at those categories. For the purpose of writing up the theory, I think that it is desirable to have the best exemplars to present to readers, to optimize the clarity of the presentation. It seems that since I would not actually violate any principles of the methodology by continuing to analyze and code the remaining data, I should do so, given the circumstances.

---

I have seen many criticisms of theories produced using a grounded theory methodology on the basis that the resulting theory was linear or poorly integrated. To minimize the likelihood that I, too, will produce such a “defective” theory, I will sit down with pieces of paper representing each of the categories (of all levels in the hierarchy), and attempt to discern the nature of the complex relations among them.

---

Tonight I had my living room floor covered with paper category markers. I kept close at hand the memos on each category, and went about the process of moving the markers about, in relation to one another, in an effort to create an organizational structure that most closely represents the data under consideration. I made sketches (see sample sketch presented in Figure 3-1) of the category relationships, and compared these sketches to

my holistic understanding of the data, to determine a “closeness of fit.” It seems that there is a circular, rather than strictly hierarchical relationship among the subcategories, but it is clear that there is one category that is core, or central, which subsumes the others, and this core category seems to account for most of the variance in the data. The core category of “The Client’s Journey” seems to most accurately and completely capture the experiences of clients who have experienced unsuccessful therapy. Moreover, it is a term that clients, themselves, used to describe their experiences.

---

Subsumed under the core category of “Journey” are three subcategories: embarking, evaluating, and ending, which I have related in a circular manner. I will construct a diagram that represents this association among the primary categories (see Figure 3-2). There are certain properties and conditions of these categories about which I am still somewhat confused. In particular, I am not sure if I should represent certain properties of the subcategories, themselves, as subcategories (i.e., raised up one level in the hierarchy).





**Figure 3-2.** Cyclical association among three subcategories.

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I spoke with my supervisor, and she has suggested writing up the theory and see if that process produces greater clarity on the category/property/level issue. Sounds like a good idea. Of course, I already have the substance of the theory written in the form of memos for each of the categories, so I now need to only integrate these pieces of information into a smooth, running narrative (which, essentially, is an explication of the core category).

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My supervisor and I also discussed the nomenclature that I have produced, particularly with respect to the use of the term “Journey” to

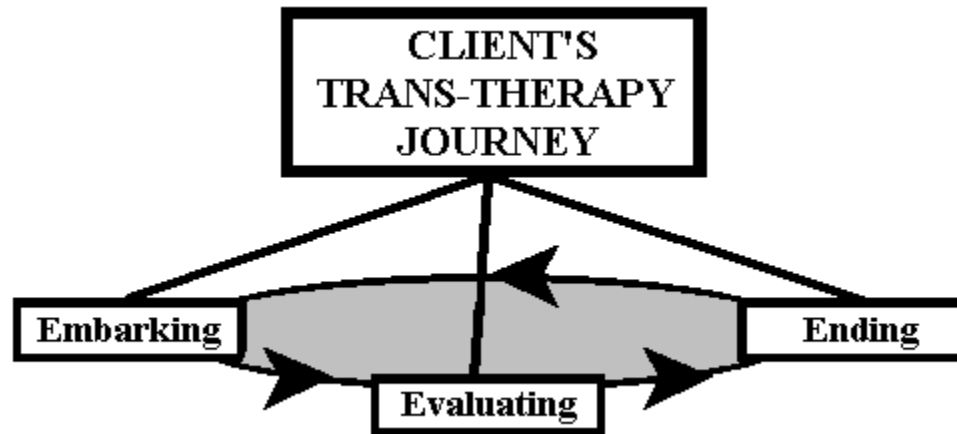
represent the core category. We share a concern that this term has been used in somewhat nonspecific fashion to represent a host of temporally-related quests that individuals may take on. Hence, there are two primary concerns about using that term to represent the core category. First, if it is sufficiently nondescript and historically overused, then it does not allow for a clear understanding of the more specific meaning intended and implied within the context of clients' experiences of unsuccessful therapy. Second, because the term 'journey' has been widely used, others may dismiss the theory as somewhat 'flaky' in nature. Neither, of course, would be a desirable outcome. I will sit with this dilemma, as I write up the final product, and see if another term is more appropriate, while still being grounded in the data.

---

I produced a diagram of the theory structure, as it currently stands (see Figure 3-3). Although there is a hierarchical structure, with the core category subsuming a cyclical relationship among three subcategories, it seems too simplistic or too linear. Parsimony is desirable, I know, but not at the expense of complexity. I need to think about this some more. For now, I'll return to writing up the theory.

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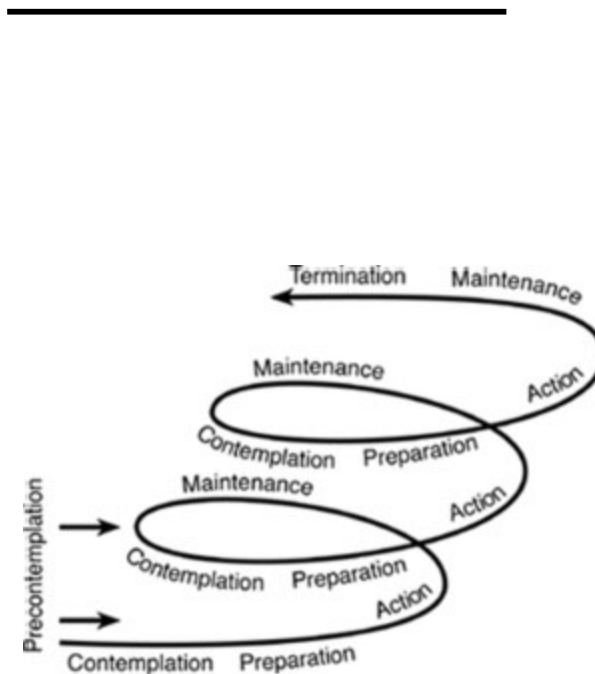


**Figure 3-3.** Model representing core and first-order categories.

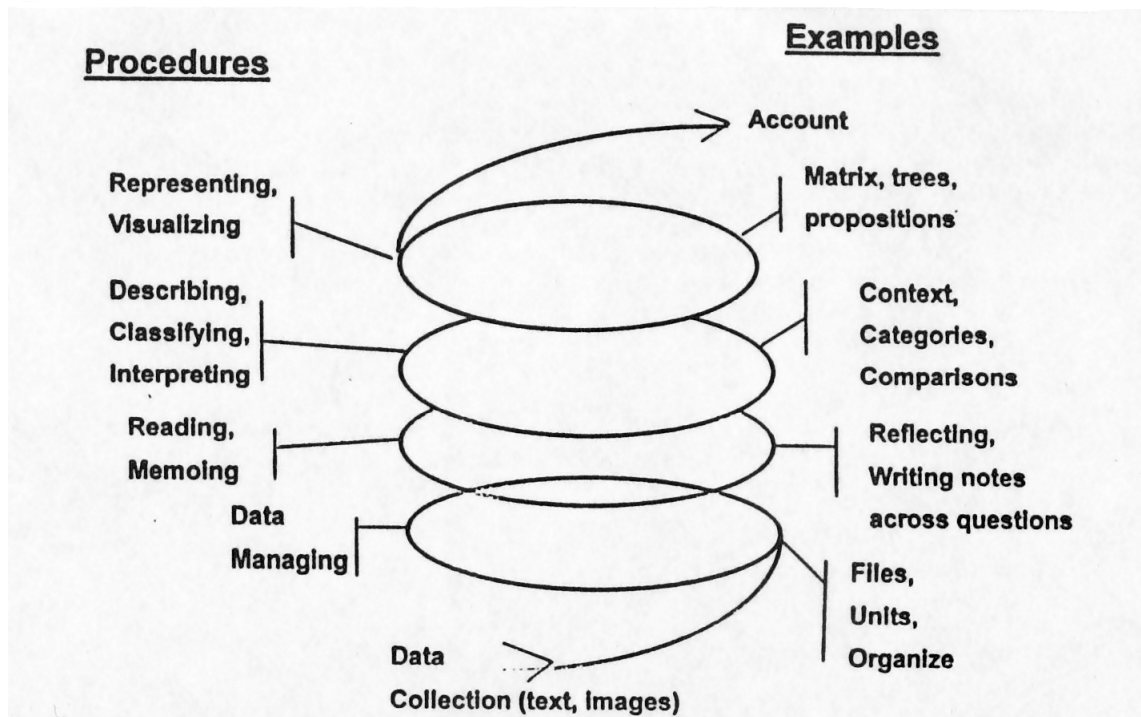
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I think I found a way of accurately representing the complexity inherent in clients' experiences of unsuccessful therapy, without producing a confusing or cumbersome model. I was thinking about Prochaska's stages of change model (see Figure 3-4), which is a helical structure representing various stages, or phases of change, repeatedly connected over a temporal course. That way of representing the associations among categories works beautifully for clients' experiences of unsuccessful therapy. When I first noticed the similarity, I had concerns that I was "copying" someone else's theory. But I most certainly am not. As Glaser has passionately written, the grounded theory analyst must be theoretically sensitive to a wide variety of possible relationships among categories. The helical representation offered by Prochaska, in the context

of explaining changes in patient behaviours, is but one way that we may make connections among categories, and in no way presupposes a given content area. Theorists have used spiral images in non-clinical contexts, as well, to represent the connections among various processes and categories (e.g., the “Data Analysis Spiral” put forth by Creswell, 1998; see Figure 3-4).



**Figure 3-4. Transtheoretical Model of Behavior Change (Prochaska & DiClemente, 1982).**



**Figure 3-5. The Data Analysis Spiral (Creswell, 1998, p. 143.).**

I have now finished writing up the theory, and have produced a three-dimensional graphical representation that captures the central categories and the relationships among them, as emerged in the current study. First, there is a circular relationship among the three process subcategories (embarking, evaluating, and ending), which is a central component of clients' experiences. As clients progress along their therapeutic path, they repeatedly engage in these three processes. Importantly, and giving rise to the helical (versus circular model), with each "pass" through the processes, clients are advancing further in a third dimension (i.e.,

familiarity), which represents both the temporal and experiential aspects of their path. I have replaced the term, “journey,” with “path” to address my previous concerns about the former term. I am not certain that “path” is the best title for the core category, but it is the best that I have been able to discern at this point. For now, the process of theory generation is complete. Finally! Later, sometime after the defense of my dissertation, I (and others) can explore possible ways in which we should revise it.

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This undertaking has been, without any doubt, the most intellectually challenging experience of my life. With all its challenges, frustrations, stumbling blocks, and omnipresent ambiguity, I am actually looking forward to doing my next grounded theory study!

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A culturally sensitive psychology . . . is and must be based not only upon what people actually *do*, but what they *say* they do and what they *say* caused them to do what they did. It is also concerned with what people *say* others did and why. And above all, it is concerned with what people *say* their worlds are like.

– Bruner (1990, p. 16)

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## **CHAPTER FOUR:**

### **THE CLIENT’S HELICAL PATH**

#### **4.1 The Core Category**

The Client’s Helical Path emerged as the core category from the data set of interviews with clients who have had unsuccessful therapy experiences.<sup>13</sup> Three cyclically-related subcategories, Embarking, Evaluating, and Ending, and one further subcategory, Familiarity, which provides a temporal and experiential dimension, cutting across the relationship among the first three subcategories, represent this core category. The three cyclically-related subcategories represent processes in which clients engage, and which they revisit as they move along their experiential path, as they become increasingly familiar with the enterprise of therapy. Thus, there is a reciprocally deterministic relationship between the three cyclically-related subcategories and the linear subcategory: As clients pass, or cycle, through the former, they advance with respect to the latter; similarly, as clients advance with respect to the linear dimension, they necessarily cycle through the former processes.

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<sup>13</sup> I have chosen to present the theory using language that presupposes that the experiences of the 11 client-participants are representative of those of other clients (e.g., “Clients believe ...”; “Clients perceive ...”). My choice represents a stylistic preference more than it does a statement about the possible fit of the theory with the experiences of other clients.



It is possible, too, that this particular figure could represent a theory other than that of the Client's Helical Path. For example, the basic helical structure relied upon in this visual representation also might be suited to represent the 'path' of clients who have had multiple *successful* therapy experiences. Indeed, it is plausible that this figure might have some utility in representing a higher-order, formal theory of clients' experiences of both successful and unsuccessful therapy, that would be generated from future grounded theory investigations.

When we evaluate clients' experiences of unsuccessful therapy at the level of a single therapeutic experience, we have necessarily decontextualized them from the broader therapeutic path along which such clients travel. Unlike therapist-centric research, the current theory has emerged from the voices of clients from whom, and only from whom, we can glean a contextualized understanding of their experiential path, which unfortunately often comprises recurring experiences of unsuccessful therapy.

The concept of a "path" is one that clients allude to when describing their multiple unsuccessful therapy experiences and is, therefore, well grounded in the data. As C6 stated:

C6: I always feel like I'm on a journey, and I choose to go down this road, and it's all covered in ruts and muddy . . . so, I say, "Oh. Ok." So I go down another road, and it's gravel - it's a little bit better. And I'm still going forward.



Further, clients, such as C10, describe their path as encompassing a “cycle,” which provides evidence for the groundedness of the cyclical relationship that this theory proposes among the three primary subcategories of The Client’s Helical Path:

C10: This time I’d made up my mind, for sure, that I was never going back. And then I would just basically give up on professional help. But, over time, it seems like I would cycle. Every year or two, I would get bad enough with the eating disorder that I would think, “I have to do something, because what I’m doing isn’t working.” So, I guess maybe something inside me kept saying, “Well, just keep trying. Maybe it’ll be different this time.”

I turn now to a discussion of each of the four primary subcategories, beginning with the linear, temporal, and experiential dimension of Familiarity.

#### 4.1.1 Familiarity

The Client’s Familiarity has properties of **experience**<sup>14</sup> and **understanding**, which necessarily increase over the course, or time continuum, of movement along the Client’s Helical Path. Clients embark upon their therapeutic paths with varying degrees of familiarity with the ‘system’ of therapy. Positioned at one end of this continuum of familiarity are clients who have never before engaged in the work of therapy, and whom

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<sup>14</sup> Properties of the first-order categories are printed in **bold underlined font** for their first presentation within this chapter.

I refer to as ‘**novice clients**’<sup>15</sup>. The status of ‘novice client,’ in the context of the client’s path, is quickly lost once the client embarks on her first course of therapy. Toward the other end of this continuum of familiarity are ‘**repeat clients**’ those clients who have previously embarked on a course of therapy and, therefore, are no longer novices. Clients positioned at either end of this continuum differ significantly both in terms of their therapy experience with and their understanding of the enterprise of therapy.

The lack of familiarity that defines the status of novice client implies both a lack of experience and a lack of understanding of the therapeutic enterprise. Moreover, understanding of therapy is not necessarily explicitly provided to them by either the first therapist with whom they work, as a novice client, or therapists with whom they work in later courses of therapy. Indeed, perhaps it cannot be, as such an understanding is arguably experiential rather than purely verbal in nature. Nonetheless, the lack of explicit discussion and therapist-led ‘training’ about the nature and processes of therapy is a source of concern particularly to novice clients, as articulated by C7:

C7: It wasn't explained what counselling was all about. And I had no ideas. So, I think that would have been a really good place to start. For example, I wasn't told I could say "No." And, given what I'd experienced up to that point, that would have been a really good thing to know, that I could say “No” to the techniques, or what she was doing.

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<sup>15</sup> Properties of the properties of the first-order categories are printed in ***bold italicized font*** for their first presentation within this chapter.

Despite novice clients' lack of familiarity, experience, and understanding, they nonetheless embark upon their path (which is a much larger and more dynamic experiential journey than is a particular course of therapy) having expectations for the process, the dynamics of the therapeutic relationship, and the outcomes of their upcoming therapeutic work. Unlike repeat clients, novice clients have no experiential base for comparison and evaluation of their current therapy experiences. I asked C9 what kind of expectations he had as a novice client, when he first went to see a counsellor. His response demonstrated two aspects, or properties, of the Client's Familiarity. First, it demonstrated the naivety with respect to the enterprise of therapy that clients recognize in themselves, as novice clients. And second, it demonstrated the changing level of familiarity that occurs over time, as evidenced not only by the passing of time, but by the shifting perspective that clients have about therapy as they become more familiar.

C9: My expectations, I think, were just extremely and unrealistically high. I sort of envisioned that after a few sessions of talking to someone they would point out some magical little button in my brain - like Data on Star Trek. You'd open the flap, you'd take a screwdriver and crank it one-quarter turn, close the lid, and everything would be marvellous again.

The Client's Familiarity has direct bearing on the process of Embarking on a particular course of therapy, which, for each client, evolves substantially over the course of the Client's Helical Path, as familiarity with the enterprise of therapy becomes

enhanced. Similarly, the Client's Familiarity implicates the nature and quality of Evaluations performed by clients, and ultimately affects the Endings that bring to a close particular courses of therapy. Thus, there exist causal relationships between the Client's Familiarity and each of the other three subcategories.

#### **4.1.2 Embarking**

Embarking represents the initial process for the client within a particular course of therapy, but it is a recurring process that the overarching helical path revisits and contextualizes. The process of Embarking presupposes that clients enter therapy with a particular mindset, and has properties of their desires, feelings, and the therapist-client communication about that mindset.

There is a clear connection between the process of Embarking and the Helical Path along which clients are moving with respect to their therapeutic experiences. Clients experience greater *clarity about their desires for therapy* each time they encounter the Embarking process, as they become more familiar with the enterprise of therapy and as they concurrently move along their helical path. Generally, clients experience this as a positive development because they believe that greater clarity with respect to their entering mindset, manifest in the process of Embarking, increases the likelihood that therapy will be successful. Nonetheless, when clients become more clear about their desires for therapy, they also become more aware of when those desires or expectations are not being met or, in other words, they are more clear that therapy has become unsuccessful.

Clients' desires reflect their hopes and expectations for what the process of therapy will entail, and for the ways and degree to which it will help them. ***Clients expect that their therapists*** will be both knowledgeable and able to help them, but do not expect that all therapists will be able to help all clients. Clients expect that therapists will be honest about and aware of the bounds of their areas of competence, and provide a referral to another professional if the circumstances indicate that. A failure to do so can result in the client experiencing therapy as unsuccessful, as articulated by C10:

C10: I expected knowledge. I expected that if I was going to a professional, that they would know how to help me. And with all of those people, that wasn't the case. And so, I can accept the fact that there is so much to know, I do believe not every person can know everything. But I do believe that it is a professional responsibility for anyone working in the area to say, "I don't have expertise in this area. I need to refer you to someone else." So, that was an expectation that was not met.

As part of their set of desires, clients hope that there will be a shared understanding with their therapists about the issues to which both parties, in collaboration with one another, need to attend and focus upon in their therapeutic work together. When clients do not perceive that their therapists are 'on the same page' as them, they come to view the therapists as confused, and the therapies as confusing. Regardless of whether therapists are 'correct' about the issues of central therapeutic importance, it is clients' unmet expectations for a shared understanding that they relate to

subsequent evaluations of therapy as unsuccessful. C7 and C8 provide examples of clients' desires for a shared understanding and focus with their therapists:

C7: There seemed to be some confusion as to why he thought I was there. I thought I knew what I was there for. He was just really arrogant. I recall writing in my journal that it sounded like he was a used car salesman . . . like, "this is what I can do for you". . . . He did his psychological assessment, which wasn't explained. . . . I thought I knew why I was there, but he had different ideas. I thought I was there for the effects of the accident. So, I was trying to get retrained and cope with no money, and those things. And he thought I was there for pain management and chronic pain. And, yeah, I'd been in chronic pain, but I'd just had surgery! So, as far as I knew, I didn't need that service. But, he did. So, that was very short. I think I met with him three times altogether.

C8: In the first session, I put the abuse type stuff on the table, but I think I minimized it. I think I really said, "Here's why I'm here - it's abuse. My wife says I'm being abusive." And she very quickly said, "Ok. The real problem is . . . ." So, I think rather than focus on that, she quickly took it off in a direction that she wanted to go with it.

Clients expect that, in the event that they and their therapists do not find themselves on the same "wavelength," at very least there will be a willingness on the

part of the therapist to respect and understand the client's perspective. C3 described this type of desire, or expectation, as follows:

C3: Say you are my counsellor, and I have this theory of self, and you have a different one. We need to at least talk about that. Because I can't evaluate you, you can't evaluate me, and therefore can't help me onto the next step if you don't understand. And I didn't realize that until after these circumstances. And then I sort of came to the realization that for a good therapy or counselling session to progress, you need to be on the same wavelength. And even if the counsellor doesn't agree, they at least need to be able to understand and see how this person's thinking - their logic.

At a very basic level, clients hope that therapists will validate and nurture them for making a choice to seek out help, and believe that such validation is critical to helping them overcome feelings of shame and secrecy about their problems. C10 described that the therapist providing immediate validation and nurturing is a sine qua non of viable therapy:

C10: What I wanted to have happen was to have someone - first of all - say that it was ok for me to be there. Like, I felt so much shame and so much secrecy around the eating disorder. I needed someone to validate me - first of all - for even being there. You know, to say, "It's so good that you were able to reach out for help. I'm so glad that you're here and that we can work

together.” That would have made so much difference to me. I had that expectation. I really wanted someone to be so kind and so gentle, and I just so much needed to be nurtured. . . . And until that was attended to, nothing else mattered.

In a similar vein, C6 pointed to clients’ desires for affirmation and some “building up” by therapists, whom clients see as knowledgeable:

C6: The therapist had access to the books and the research. He could say, "Yes, this is normal," and I could believe him. A lot of people haven't been through the same experiences, or been with people who've been through the same experiences. So, they're like, "Oh, gee, I don't know. Maybe you are crazy.” I needed affirmation, and to be told that I wasn't truly looped. As silly as it sounds, I just needed some building up.

In general, various qualities of the therapist constitute a central type of, and are characteristic of, clients’ desires for their therapeutic experiences. Clients expect that therapists will be “there for them,” and will be “in their court,” which they may not experience in relationships with others, outside of therapy. Clients hope that their therapists will be safe to be in a relationship with, and ground this hope in these individuals having the role or title of ‘therapist.’ They also expect that therapists will have already done “their own work,” so that their own unresolved issues do not unduly influence therapists’ views. Interpersonally, clients desire therapists who are honest,



have a sense of humour, are able to “come down to their level,” and are nonjudgmental, as described by C11:

C11: I guess that the perfect therapist person would have to be sort of honest.

One that could come down to your level, without being overbearing or feeling superior. A sense of humour is always important, I think. Somebody that you can tell that they're excited about life, themselves. Yeah, so I think a sense of humour is probably very important. Someone that laughs easy. And somebody that's not judgmental. I think someone you can relate to is important - being able to identify with you.

Beyond having desires for specific qualities of the therapists, clients also embark upon courses of therapy with *expectations for the therapeutic process and what it may be able to offer to them with respect to alleviating their current distress*. Clients expect that therapy will provide them with a venue for working through their problems, one that goes beyond what is available to them through social friendships and one that provides to them a “release valve,” as described by C5 and C6:

C5: I've got a lot of problems I'm dealing with. There are a lot of changes in my life, and I sort of want someone to talk to. Even if I'm talking to my friends, you can't really share all of the details with them . . . these are things that I just don't have anybody to do that with. They're almost too personal to talk over a beer with my co-workers.

C6: It's like you think it's going to build up in you like a volcano, and you just need a release valve. And I didn't really have anyone around me to talk to that much. I have my husband to talk to, but it's helpful to have somebody else, too. And I didn't have the support, really, of really good family around me then. And it kind of makes you miserable, walking around really charged. And it's hard to live with, as it would be hard for my husband and everyone else to be around. That's not how I like to be. So, even for that release . . . that's why I started going.

Clients' expectations of therapy vary over time, as they progress along their helical path and re-engage in the embarking process. So, too, do their expectations, or desires, evolve within a particular course of therapy; the set of desires that clients embrace is not rigidly fixed. They may initially be expecting "superficial" or "practical" support, and later in the same course of therapy expect "deeper" support. The therapist may meet expectations of one sort, but not those of another sort, giving rise to the potential outcome of unsuccessful therapy, as C7 explained:

C7: The therapist provided more what I would call 'superficial assistance'. Like, day-to-day tasks. And that's what I needed at the time . . . like, "What do I need to do to get some money so I can live until I finish off with these law suits?," "What do I need to take care of myself?," "What do I need in terms of planning for future surgeries?" So, it was really practical in nature, and

that's what I needed at that time to kind of get me back on my feet. To kind of navigate my way through these systems that I had got into. So, initially, he was very helpful. But then, I think once I got things settled down, then I was looking for something deeper. But this guy wouldn't even touch anything to do with emotions, or anything other than the practical, day-to-day kinds of issues.

As clients work through the embarking process of their helical path, they recognize that they have hopes that they will develop a sense, within their first few sessions, that feeling comfortable with and having confidence in their therapists is, at least, a possibility that exists, albeit one that clients might not realize until later in their courses of therapy. Clients do not expect that such comfort and confidence will emerge immediately, but they do have a clear desire for there to be immediately-apparent 'kernels' of confidence and comfort. Moreover, such kernels are necessary for clients to continue with what they often perceive to be the risky enterprise of therapy, as described by C10:

C10: As a client, I need to feel in one or two sessions that you're going to be able to help me. Now, I'm not saying that you're going to help me in one or two sessions, but I need to feel that it's going to work in one or two sessions. Otherwise, I think, what's the point of going on. I need to have a good feeling about it. Like, I need to know that this feels good, and it feels like it might actually help. And if I get that feeling that I'm going to be

comfortable and that I could maybe grow to trust this person, and I think they might have the knowledge to help me, then that's my incentive for coming back. And if some of those are missing, if I'm not feeling comfortable or respected or that I could grow to trust that person, it's almost like an atmosphere type of thing. And if it's not there at the start, it'll never be there, in my opinion. Safety is critical.

A second fundamental property of the Embarking process is the range of feelings experienced by clients as they begin a particular course of therapy. As with their desires, we need to understand the types and presence of such feelings in the context of the continuing helical path along which clients are experiencing movement. Novice clients, those with less Familiarity, often embark upon a specific course of therapy feeling confused, uncertain, and scared about what lies ahead. Clients in general, but particularly the novice clients, also make attributions for some of their unpleasant feelings during the Embarking process to the 'stigma of therapy,' which they perceive to exist in society. They may, however, also feel hopeful about their therapy future.

It is not only novice clients who experience unpleasant feelings upon embarking on a course of therapy. When the helical path-to-date of more experienced clients has included one or more experiences of unsuccessful therapy, such clients feel even more trepidation, scepticism, nervousness, and general discomfort than they experienced upon embarking on their very first course of therapy. I asked C6 how she was feeling as she walked into her third counselling experience, after having two previous unsuccessful experiences with therapy. She replied:

C6: Quite trepidatious . . . thinking that, you know, this is going to be another soul-baring experience. But, I said, "Ok." Because I believe that you have to go out on a limb to get the fruit."Ok. So here we go." I do recall noticing going in being sceptical, but not about therapy, as a whole. I wasn't thinking in terms so broad. More specific to the particular therapy I was entering.

This highlights an important element of the client's mindset upon embarking on a course of therapy, and its relationship to the core category of the Client's Helical Path. When a client's path-to-date includes a history of one or more unsuccessful therapy experiences, she or he may or may not generalize their resulting negative thoughts and feelings to the broad domain of "therapy." Limiting the degree of generalization is, in fact, what allows clients to muster up the courage to continue moving along their path toward embarking upon future therapeutic experiences and to maintain hope that the enterprise of therapy is not flawed. The previous comment by C6 indicates that she felt sceptical about the third therapy experience upon which she was about to embark, and consequently experienced feelings of doubt upon doing so, but did in fact proceed because her hope for 'therapy,' as an enterprise, was still in tact.

With increasing familiarity and movement along the helical path, the client's mindset evolves, but the feelings experienced upon entering, rather than the desires or expectations that clients hold, may account for the changes inherent in a future process of embarking. C10 explained:

C10: I think I went in far more cautious, the second time. I don't think the expectations were a whole lot different, but I feel I was more guarded, in terms of my emotional state, I suppose. Because I didn't want to have the same impact. And, the second time around, I was still unhappy, but I don't think I was so emotionally impacted, because I kind of went in braced - this second time.

There is great variation with respect to the ways and degrees to which the client's mindset upon embarking on a course of therapy is brought into the therapeutic discourse. Clients may experience their therapies as "just talking about whatever," in which cases the therapeutic discourse does not explicitly address either clients' desires or feelings about therapy that they hold upon entering the encounter. This was the case for C6 who consequently found therapy to be chaotic:

C6: I think, in the first therapy, we just talked about whatever. And I have so many issues that it just doesn't work for me, because I was just like a Pandora's box. And so that was useless. It was just too chaotic.

Clients are aware that therapy is taking place on the therapist's 'turf,' and they therefore expect that the *therapist will take the lead with respect to eliciting the client's expectations*. Clients view therapists as 'professionals' with respect to the therapy process, and when therapists neither ask nor invite clients to discuss their expectations, they assume that such communication must not be a part of the unfolding therapy

experience. In this respect, type and style of communication between the therapist and client implicates the Client's Familiarity with therapy; novice clients are more unaware of the ways in which therapy may play out, and are more likely to follow the therapist's lead.

C10: Nobody ever invited anything from me about my expectations - ever. It was always, "Come on in" and it's kind of their way, kind of thing. And on my side of it, I would have never thought to offer my expectations. Because I was thinking, "Well, they're the professionals. I guess they must know how to do this, or what's best."

In other cases, therapists ask clients, during the embarking process, to identify their "objectives" for therapy, thereby providing an opportunity for communication of the client's desires and feelings regarding the ensuing course of therapy. Some clients, though, without any invitation from their therapists, *deliberately offer their desires and feelings for consideration*. Whether or not such a move creates a positive outcome is dependent upon the manner in which the therapist responds.

Clients need their therapists to be open to listening to and understanding their desires and feelings, and to the way that their previous movement along the helical path has shaped their mindset. Clients are not willing to have their desires and feelings "shoved away" by their therapists. At very least, they need therapists to be open to discussing their perspectives, even if the therapist does not agree with them. Failure on the part of the therapist to do so may produce an unsuccessful therapy experience. C6

described how she deliberately and explicitly brought her embarking mindset into the therapeutic discourse, because her increasing familiarity with the enterprise of therapy had taught her that not doing so was ‘chaotic.’ Unfortunately, her *therapist did not respond in a desirable manner*, and the outcome was unsuccessful therapy:

C6: I tried bringing them up with the third fellow, that "I want to deal with this, this, this, and this, and I think we should do it in this order." Because I wanted some structure, because I wanted to avoid the chaos that I was feeling. And so, in order to address that chaos, I did bring to him a kind of ‘plan’. But, I thought that he seemed a little unenthusiastic about it. He just kind of, "No, I don't really want to do that kind of thing." I don't know - because he didn't say that or anything. It's just being oversensitive again to any sort of rejection of my ideas. So, I put it away. And that was basically it. It was a bit of a slap. Not, maybe, that harsh. But it was a block - it was a road barrier. Because I was flowing along quite happily, and then suddenly "Bang!" Oh, ok. Can't go there. And so I kind of continued around it for a little while, but I found that I needed something different. Because it just became emotional upheaval again . . . every time I went, it was not going anywhere.

C6 also described how uncomfortable she was about taking what, to her, was a bold step of making her desires for therapy explicit, and suggested ways that her therapist could have responded to her efforts, which may have prevented therapy from



becoming unsuccessful. It did become unsuccessful, though, and C6 consequently packed her therapeutic bags and left:

C6: When I brought forth my plan . . . I was very nervous about making any suggestions to what he's doing, or criticizing him . . . just being more positive about it. You know, he could have said, "Well, ok . . ." Or maybe explored it a little bit further. That would have helped. And if he would have had a plan, himself . . . he didn't seem really clear about that. It kind of got shoved under the table. Probably I just shut up real quick, as soon as I sensed any kind of rejection from him. I couldn't go any further. And suddenly I had a block, and that was it. You know, I've had a lot of blocks in my life, and I've persevered through them. But for some reason I'm not willing to do it in therapy. I was happily unpacking all the baggage, until suddenly this fellow says, "Well, I don't really want you to unpack those bags. Leave them sitting there." So, I grab my bags and say, "See ya. I'll go somewhere else, I think."

#### **4.1.3 Evaluating**

Evaluating constitutes a third category of the Client's Helical Path, and has properties of **laying blame** and **contextualizing**. Clients continually engage in a process of evaluating their progress in therapy and, more importantly to them, they evaluate the degree to which their desires or expectations, present since embarking, are being met by both the therapy and the therapist. This process of evaluating involves searching for

explanations of why their therapy is unsuccessful. Further, there is a reciprocal, bidirectional causal relationship between Evaluating and the Client's Helical Path.

Clients may lay blame on either internal or external sources or, in the language of other psychological theories, clients make both internal and external attributions for their successes and failures in therapy. When clients evaluate their therapy as unsuccessful, they give consideration to who or what was at fault. They *may externalize blame to the therapists or the therapies*, they may *internalize blame and hold themselves accountable*, or they may *construct shared attributions* for the unsuccessfulness of their therapies, and point to a poor fit between themselves and either the therapies or the therapists.

Clients often externalize blame for their unsuccessful therapy experiences to a failure on the part of their therapists to be “on the same page” as them. This may take the form of clients perceiving that therapists are forcing clients’ stories into some preconceived ‘mould’ with respect to the type or etiology of clients’ presenting problems. Clients believe that, in such cases, therapists are creating a faulty understanding of their “data,” as C3 and C6 explained:

C3: This agency that I was referred to . . . I understood they deal with an awful lot of abused kids, and they see this all the time. And I thought, "Ok, well maybe she's just so used to that type of background, that her mind is working under those circumstances so often that I just look like I fit in the pattern." But, to me, as a scientist, that wasn't taking the data and interpreting what

you really saw. You were prejudging it. And I didn't want that. So, that's why I think it was unsuccessful.

C6: I felt like she was trying to squish me into a definition or something, so that she had a framework . . . "Ok, you're this. So, that means you need to do this." Like, "It is grief, so you have to go through these stages." And it's like, "Well, I'm not going through these stages." And she said, "Oh, you will. They're being suppressed." So, when she told me I should be angry, I started thinking, "Well, am I supposed to be angry? Am I suppressing things?" I got the message, "Damn, you better fit in my textbook definition of who you should be." And it's like, "Ok, sorry." I didn't know what she was thinking.

Another form that "not being on the same page" may take is when the therapist fails to "start where the client is." As C10 explained, therapists who do not match their therapeutic maneuvers with the client's functioning and desires, at the time of embarking, are destined to have unsuccessful, and brief, courses of therapy with their clients:

C10: Many years later, when I took my social work training, there was something that they said over and over and over that just really rung true for me. They always said, "Start where the client is." And that's what every single one of my therapists did wrong. They did not start where I was. I was scared, I was vulnerable, I felt embarrassed, I felt like I didn't know these

people, I didn't trust them. They did not start where I was. Where I was was that I needed that acknowledged and validated. There won't be therapy beyond two or three sessions unless you start where the client is. Like, that woman that took all the family history . . . it doesn't matter that she has ten or twenty pages of family history on me sitting somewhere in the city, because there's no client anymore. You have to pay attention to what the client needs at any given point in time, for there to be continued therapy.

Clients may evaluate that their therapists' lack of objectivity undermined their therapeutic work together. Clients hypothesize that this lack of objectivity relates to some unresolved issues in the life of the therapist, and they believe that therapists should excuse themselves when their work with particular clients activates these personal issues such that their ability to be sufficiently objective becomes compromised. Moreover, clients do not believe that it is incumbent upon them to 'help' the therapist work through such issues. Clients suggest that therapists who fail to recuse themselves in such situations are behaving in an 'unprofessional' manner. C1 and C6 highlight these particular external attributions:

C1: The accountability was missing. And the objectivity - I think that's very, very important - was totally missing. For whatever reason. Maybe it paralleled something in the therapist's life. And if it paralleled his life, he should have excused himself, is my thinking. I'm not saying you can deny a life, and it will affect you. I realize that. Like, if someone's who's freshly

divorced has to deal with someone's who's freshly divorced, how would you do a good job of that? Because, it doesn't matter how much training you have, it hurts. If you do grief counselling, and you've just lost your child or parent, you might not be effective for a while in that arena. That makes sense to me. You excuse yourself.

C6: Really, I look at it as a service. And they're there to serve me, not the other way around. And I think that's really where my unwillingness to work through problems in communication between the counsellor and myself . . . you know, there are more counsellors out there. And that's not my job. And, if they're going to help me, that's great. I'll come and see you, and I'll be very grateful for it. But, if you've got issues to work on, go work on them. I'll see someone else right now.

Clients may interpret behaviours of therapists in a manner that leads them to believe that the therapists are either disrespecting or rejecting them, clients commonly offer such interpretations as attributions for unsuccessful therapy. C10 described her evaluation of the “busy therapist” with whom she ultimately had an unsuccessful therapy experience:

C10: So, at that time, I was very much a people-pleaser, and decided, "Well, I guess if this guy thinks that's what I should do, I'll do it." So, he put me in this room for over an hour to answer all these questions on the computer,

and left. And then, when I was finished, he popped in for a few minutes, and asked if everything had gone fine. I said, "Sure," and left. And the impact of that, to me, was that I didn't feel important at all. I thought he hadn't attended to any of my feelings or anything that I was really going through. And it just was very negative. I guess I really needed some validation at that point, that it was all right that I came for counselling, and that it was a good thing, and that he was there to help me. And I didn't get that feeling at all. It was just like he's so busy, and I was a bother to him. And putting me on the computer to answer some sort of standardized questionnaire was harmful to me, at that time, with the fragile emotional state that I was in. So, I left. I thought, "Well, I'm never going back to that guy."

Clients may also feel dismissed, minimized, and insulted by their therapists, and such feelings invariably give rise to an evaluation of therapy as unsuccessful. Such feelings may arise in a number of ways, but most often they emanate from the impact that a single comment of the therapist has on the client, as was the case for C2:

C2: The therapist was very nice, and he said, "come in, sit down, and tell me about yourself." And it took a long time. And I was just about to say, "So, you see, this is the question I have and what can I do about it," when he looked at his watch and said, "Yes, well, lots of women feel like you do. You have to go now." I had a reaction to it, but I didn't feel safe saying it at

the time, but of course what I wanted to say was, "what on earth has it to do with me if lots of women have this?" "What do you do with lots of women?" "Do you do this with lots of women?" "Or am I supposed to shut up about it because lots of women have. . . ." The indication was lots of people do. And when a helper says, "we all have this," this is very dangerous because this isn't saying "we all have this," this is saying, "you're making a fuss about something that other people aren't making a fuss about, and would you please shut up."

Clients identify the unwillingness of therapists to process or accept responsibility for problems that arise between them over the course of therapy to be another cause for unsuccessful therapy. Further, clients experience such occurrences as "retraumatizing" in nature, as was the case for C2:

C2: The damaging thing, why it didn't work, was not the fact that she lost her temper, or that she became afraid. It was her unwillingness to process it with me, and take responsibility for her fear. Not the fact that it happened. I mean, a counsellor is human. You might decide that the client isn't responding, or that maybe you don't like the client very much. I mean, there are a hundred forms of response to a particular person. But, to be unwilling to process that, to be honest in saying, "I'm going through a divorce," or "something's happening and I lost it," that was the damaging part. That was the thing that was retraumatizing.

Although environmental aspects of the therapy setting may not be experienced as “traumatizing,” clients may attribute the unsuccessfulness of their therapies to such features. For example, therapists may organize their office space in a manner that does not facilitate the clients’ comfort, or may physically position themselves in a manner that clients experience as off-putting, as was C7 recalled:

C7: I remember she would take notes. The room was set up so that I was along the wall on a couch, and she was in the other part. And there was a long table between us, and then she had her footstool. And she had her feet up on the footstool. So, it was like there was a barrier between us. And she would write notes the whole time. And it would just drive me crazy! I didn't know whether I should pause until she could catch up in what she was writing. So, that added something that didn't help the dynamic.

The demeanor of support personnel, too, is a characteristic of the therapy setting about which clients are cognizant, and to which they may attribute some blame for the quality and extent of their unsuccessful therapy experience. For example, C10 drew parallels between the cold demeanor of the receptionist and her employers (i.e., the therapists):

C10: The very first contact of any counselling experience is always the receptionist. And even though that's not like a psychologist type of thing, the receptionist can make such a difference in terms of how the client feels



when they first come in, before they even meet the professional. And these two therapists had probably the worst . . . well, I guess the receptionist for them fit them very well. Because she was just like them. Very cold, very unwelcoming . . . which is exactly how it should not be. So, anybody who is working in a counselling office should know how to treat people when they come in.

Clients tend to attribute unsuccessful therapy to these types of environmental or behavioural occurrences only when they exist within the context of therapies that are not meeting their needs in other ways. Nonetheless, clients hypothesize possible connections among these experiences and other attributes of therapists with whom they have had unsuccessful therapy, as C7 went on to explain about a different therapy experience:

C7: I became aware of details of, say, how the rooms were set up. And now looking back, that might have had an impact. Like, the last guy - his minister chair. He was sitting in a big office desk with his big office chair, and he would just turn it. So, I'm sitting at the corner. It reminded me of when you're in school and you go to the principal's office, or you sit beside the teacher's desk. And that's what it was like. That might - in part - reflect his discomfort in really dealing with people, which might have impacted, say, why we didn't talk about emotions.

Clients may evaluate the nature of therapy, itself, as failing to meet their needs and, consequently, giving rise to a particular course of therapy being evaluated as unsuccessful. For example, the enterprise of therapy may dissatisfy clients because it does not tend to accommodate the “other players” related to their problems in the therapy room, as C3 described:

C3: As I worked through this with this therapist, I realized that it was completely unproductive. It's like a marriage where you don't get the husband in there. Well, it was one of those things. Unless you can bring in some of the other players, you can't resolve anything.

Clients also point to therapies evolving into forums for “just talking” with their therapists as contributing to their evaluations of therapy as unsuccessful. Clients certainly appreciate the value of ‘talking,’ but suggest that this does not produce more than a temporary, and unsuccessful, fix. C6 described her perspective:

C6: Just talking doesn't work. Talking is a tool. And at least one of you needs to have an objective idea of what you're going to do with this, and how you're going to use it. And you can't just open it, and just blather it all out, because it doesn't go anywhere. It just fritters off into space. It tires you out, and wears you out, and "Man, I feel good, because I got all that junk out of me." But, “Heh, look at this. It's coming back again.” Because you haven't learned any new patterns of bringing material into yourself. Of interpreting things,

and processing things. You haven't learned to put any new filters on there. Or ways of processing things. You're just getting it all out. So, basically, you're stuck in talk therapy for the rest of your life. Sure, you can be affirmed and feel better about having all this junk, which is good. But, it doesn't get rid of it, except temporarily.

Although clients expect positive, or helpful, outcomes from their therapies, and base their evaluations of the degree of success of their work on such expectations, there are circumstances where clients do not evaluate therapies that do not produce positive or intended results as highly unsuccessful. C10 illustrates such a circumstance, in which the positive manner of the therapist was more influential than the negative outcome with respect to the client's evaluation of their work together:

C10: It was unsuccessful in the fact that he wasn't able to help me. Because I went in with the expectation that he was a psychologist and that he could. When, in fact, he couldn't. So, in that sense, it was unsuccessful. I was no better off having seen him. But I didn't feel the same sort of intensity of negative emotion that I'd had with the other ones, because he said right up front that he couldn't help me. And I liked that. I respected him for doing that.

Clients may also internalize blame for the unsuccessful nature of their therapies. They scrutinize what it might have been about their desires for therapy or their

familiarity (or, lack thereof) with the therapy 'system' that may have contributed to therapy becoming unsuccessful. In general, clients' evaluations of therapy as unsuccessful are usually predicated upon a perceived gap between their expectations and their experiences.

In their efforts to make sense out of their unsuccessful therapy experiences, clients have a tendency to retrospectively judge the content of their set of desires, or expectations, upon embarking on a course of therapy as perhaps having been "unrealistic," and consisting of expectations that any therapist or any therapy could not possibly have met. These judgments are harsh, and do not usually take into account how a minimal Familiarity with therapy may also be a contributing factor. C9 described his retrospective evaluations of his desires upon embarking, to make sense of his feelings of disappointment surrounding an unsuccessful therapy experience:

C9: I remember being somewhat disappointed - maybe not so much in the therapist, as in myself - for not having discovered what the key should be. I thought it was a magical little button you could adjust. And after a couple of meetings you would find some secret to life that would suddenly make it all make sense. And one's own life situation, one's own self-image . . . will all kind of be miraculously solved in a very short period of time. So, I remember being disappointed that it seemed that I kind of slid back to where I was, and things didn't appear to be any better. Because something that you had so much hope for didn't work out as you expected. But, again, not wanting to criticize the therapist, I think it leads one to more self-criticism.

That you weren't strong enough, or weren't insightful enough, or smart enough to see some way through this whole mess.

Clients believe that having unclear expectations, even if not unrealistic, has the potential to impede the therapy process, make it more likely that therapy will “not go anywhere,” and ultimately end with an evaluation of it being unsuccessful. However, clients also expect their therapists to assist them in clarifying their desires, or expectations, to increase the likelihood that therapy does, indeed, “go somewhere.” Clients are clearly not satisfied when they do not receive such help from their therapists. Clients who perceive that therapy is “not going anywhere” may end up feeling like a “wet rag,” and they suggest that “having a beer with a friend” or “talking with a spouse” would have served them equally well. In such cases, an evaluation of therapy as unsuccessful is a foregone conclusion.

Clients believe that when they are less clear about the nature of their own problems, or about their expectations for therapy, it is more likely that therapists will either passively misinterpret or more actively force their stories to fit with therapists' preexisting schema. C8 identified his proclivity to deny perceiving himself as abusive as contributing to his therapist failing to target the ‘real’ issues, which in turn ultimately produced C8's evaluation of this therapy as unsuccessful:

C8: The therapist said, "Oh. Your problem isn't abuse. It's low self-esteem. And, really, you are hard done by." Well, this was music to my ears! So, I think I quickly forgot about the reason I was there . . . but I think it was me not

having a real clear idea of what this whole abuse was. I think I paid it lip service. I think I really didn't believe that I was abusive.

C8 went on to describe how he recognized, retrospectively, that he had been 'manipulative' with his therapist, and that this had contributed to their failed therapeutic encounter. However, C8 also demonstrated that while clients are willing to accept their "share of the blame" for unsuccessful therapy, they concurrently hold their therapists responsible for behaving in a manner that is consistent with how they expect their therapists to behave:

C8: I think what happened was that she wasn't particularly well trained in abuse issues, and she had her own ideas as to, you know, my problem was low self-esteem, not abuse. And so, she went off in that kind of direction. And I was quite manipulative, too. I think I manipulated her a little bit in terms of glossing over things and portraying me in a "woe is me" light, and my wife is the "hard to get along with" type person. I think even though I didn't really say that, I think that was the impression that I gave. So, I think I was a bit manipulative, in all fairness to her, as well. I'm not condemning her approach. That was probably a reasonable thing for her to do. It's just not what I needed or had asked for at the time. I guess we both should take the blame a little bit, in terms of I went along with it. I probably manipulated the whole process to that end, as well. But, on the other hand, she probably should have recognized that.

C5, who demonstrated that clients may recognize their contribution to a less than optimal therapist-client “fit,” also described such sharing of responsibility for a failed therapeutic encounter. Nonetheless, clients also expect their therapists to take appropriate action when problems of fit emerge:

C5: Maybe an older man and a younger woman didn't fit. And I recognize that.

And maybe I was holding back a little bit from her. I didn't see it as a problem. But, nevertheless, she should have said, "I'm going to refer your file to another person, who's more into this area," or something.

We may contextualize clients' evaluations of therapy as unsuccessful *within a specific course of therapy*, but we may also contextualize them *as part of their overarching pattern of movement along the helical path*. Even in the narrower context of a specific course of therapy, clients' desires, needs, and expectations are continually evolving. Given that clients base their evaluations of therapy on the degree to which their needs, desires, and expectations are met, when therapists do not recognize that such an evolution is taking place and the therapy is not modified to stay ‘in sync,’ therapy that the client once evaluated as “successful” may later be evaluated as “unsuccessful.” As clients become more aware that the therapy or therapist is no longer meeting their needs, they become increasingly frustrated, as C7 demonstrated:

C7: The therapist provided more what I would call 'superficial assistance'. Like, day-to-day tasks. And that's what I needed at the time . . . like, "What do I need to do to get some money so I can live until I finish off with these law suits?," "What do I need to take care of myself?," "What do I need in terms of planning for future surgeries?" So, it was really practical in nature, and that's what I needed at that time to kind of get me back on my feet. To kind of navigate my way through these systems that I had got into. So, initially, he was very helpful. But then, I think once I got things settled down, then I was looking for something deeper. But this guy wouldn't even touch anything to do with emotions, or anything other than the practical, day-to-day kinds of issues. . . . I knew that my need to deal with them was building. So, I think over time I was becoming increasingly frustrated, agitated, or something along that line. And that wasn't in place with this counsellor . . . to move on with. I was ready to move on and it wasn't available. I didn't want to go anymore.

Occasionally, novice clients experience confusion about whether to evaluate their specific course of therapy as either successful or unsuccessful, because they do not have the benefit of other therapeutic experiences with which to compare their current work. They have not yet attained a sufficient level of familiarity with the enterprise of therapy and, by definition, have not previously engaged in the process of evaluating. C7 demonstrated the ambivalence and confusion about such first-time evaluations that are inherent in the novice client:



C7: I guess there would have been times when I thought the therapy was ok. But not having anything to compare it to . . . I don't know how to say it . . . I guessed it was successful. Looking back now, I would say it wasn't successful throughout. But, at the time, I think there were moments where she might have helped me to do something or realized something. Then it would have been successful. But, from what I've learned now, no.

Non-novice clients, who have attained a greater level of familiarity and have performed evaluations of therapy on previous occasions, may externalize blame for the unsuccessfulness of some courses of therapy and internalize blame for others. That is, clients do not have fixed attributional styles that lead them to consistently externalize or internalize blame for their unsuccessful therapy experiences. For example, although C3 had externalized blame to the therapist in an earlier unsuccessful therapy experience, she thought it appropriate to internalize blame to some degree in a later experience:

C3: I didn't attach quite so much responsibility for the failed interaction with this counsellor in this situation. I felt that - to some degree - I was very worn out, and I was tired of the whole thing, and I just wanted out. And I never felt like we were getting anywhere. And maybe it was my being impatient.

Conversely, C10 described making what she believed was a healthy shift, as she gained a greater level of familiarity and attained more experience in making evaluations

of therapy as she moved along the helical path, from blaming herself for an earlier unsuccessful therapy to holding her therapist accountable and responsible in a later one:

C10: I think it was a little bit different the second time. I think that I was starting to place responsibility more so where it belonged. I still felt very crushed, and I still felt, "Well, geez. I mustn't be important if they're not paying attention to me." But I was also, at that time, acknowledging that they really should have done something different there. I didn't feel that it was acceptable the way I was handled. And I was starting to separate myself from blaming myself a little bit.

Clients make their current evaluations of therapy in the context of their evaluations of previous therapy experiences. With repeated evaluations of therapy as unsuccessful, clients are more likely to generalize their evaluations to the enterprise of therapy rather than limiting them to the specific instance of therapy giving rise to the current evaluation. C6 demonstrated this tendency, as well as the potential consequence of clients choosing to give up on therapy and consequently remove themselves from their helical path:

C6: After having two unsuccessful therapy experiences, I was sort thinking that therapy was pretty useless, at that point. And that it was for more mainstream types of folks. You know, kind of the popular kids in class. Like, just a very different way of thinking and doing and being. The busy people.

You know, that it's for the career people. I thought it would be more beneficial to them, because they seemed to be more geared towards their level of thinking, which was different to my own. I started to question the enterprise of therapy. I thought there probably were good therapists out there, but it was the amount of work and effort. Every time you go there - to a new therapist - it takes so much effort. And you're just baring your soul to them, and you need to recover from that. And that had a lot to do with it, as well. Recovery time between just baring your soul. And so, that was also quite a key player in how much time it took to go try another therapist.

#### **4.1.4 Ending**

Just as Embarking represents the process of entering a particular course of therapy, Ending represents the process through which clients exit from their work with therapists. Although Ending is an expected, or natural, developmental process of the client's helical path, in the context of clients who have had unsuccessful therapy experiences, endings typically have a highly negative valence assigned. Ending comprises properties of means and shifts.

The means of endings are the ways in which clients' courses of therapy are terminated. The *decision to end the working relationship between therapist and client is, at times, made by the therapist*. Clients often experience such maneuvers as lacking a consultative or collaborative quality, and consequently perceive their therapists' decision as unilateral in nature. When therapist-motivated endings are handled in such a manner, clients experience a sense of shock and often tend to react in a negative fashion to their

therapists' decisions and manner of communicating those decisions to them. Clients may feel that their therapists have foreclosed and, perhaps, 'prematurely terminated,' their therapeutic experiences. Clients may feel rejected, abandoned, confused, and angry as a result of therapists "turning them away." C2 articulated her dissatisfaction with the manner in which her therapist chose to terminate their work together, as well as the dialogue that ensued:

C2: I had an interview with her, in which she said, "Tell me what happened." So I talked for about half an hour, and then she said, "Well, that doesn't fit the criteria." And that was the end of the interview! So, presumably what she was trying to say was that that's not what she deals with, but that's what she said. That was the only comment, "That doesn't fit the criteria. Goodbye." And I got up and I was supposed to leave.

When therapists choose to end their work with clients, they can ameliorate the degree to which clients experience the ending as a negative experience by facilitating the clients' continuation along their helical paths. C2, whom a therapist had previously bluntly turned away, revealed how significant it was for her to perceive a later therapist as helpful, even though the therapist had decided to terminate their work together:

C2: I saw a therapist - a very, very nice, busy person, who listened to what I described. And then she said, "I can't help you. This isn't in my sphere. But I

will help you find someone." I felt like Cinderella, because my search for people had been an entirely solo search up until that time.

Even if the therapist is not able or willing to facilitate the client's movement along her path by actively assisting in the referral process, thereby facilitating the next embarking process, clients expect that therapists will at least initiate a dialogue that will provide them with an understanding and context for the therapist's decision to terminate therapy. Clients are not willing to have their therapists simply dismiss them, and send them on their way. C5 depicted his experience, which he classified as unsuccessful due to the manner in which the therapist terminated their work together after several sessions, and suggested ways that the therapist could have communicated this decision in a more sensitive and effective manner:

C5: If she would have said, "We came to the conclusion that there's nothing we can do for you. You're actually managing things pretty damn well. You've got a lot of problems, but you're mature enough. You understand what the consequences are. You're doing this, you're doing that . . . if you want, we can prescribe something for you, but we'd prefer not to. Overall, you're doing ok. If you have depression, it's certainly not something that's life-threatening or doesn't appear that it could affect your health any more. Your relationship with your wife might be a constant problem, but you didn't do anything about it, so we will assume that. . . ." If she'd made something up like that . . . I never heard those words even once. Just that, "We can't help

you here. You've got to go to a private clinic to find help. You don't fit us."

That was the message. "That's not our mandate." That's exactly the words she used.

Just as therapists sometimes call therapy to an end, *clients also decide to end their therapeutic work with therapists*. In the vast majority of cases, such decisions follow from clients' evaluations that their therapy experiences were unsuccessful. There is considerable variation with respect to the type and extent of dialogue with therapists that accompanies clients' decision to terminate, however. Many clients communicate their decision by simply not returning to therapy and choose such a means of ending because either they are unfamiliar with the "therapy etiquette" pertaining to termination, or they are unwilling to invest scarce personal energy resources in the process of communicating their decision to the therapist. As C6 demonstrated, there is, therefore, a relationship between the Client's Familiarity with the enterprise of therapy and the process of Ending:

C6: I just left. I just didn't come back! She didn't seem interested, anyway. I never thought to let someone know, actually, that that was my last session. I never actually thought of that. I guess I didn't really know the therapy etiquette! I didn't make it clear that I was dissatisfied. It takes a lot of energy, and I chose not to direct it in that venue. Although I think it would be helpful to them. Yeah, it would be helpful to both of us. Maybe we could resolve things. But, it's one of those things . . . you just kind of choose where you put

your energy, especially when you don't have very much. Sometimes you chose not to.

Aside from considerations of *therapy etiquette* or scarce personal resources, clients may also evaluate their relationships with their therapists as simply not being of the sort that would necessitate a dialogue about ending. This is the case when clients experience their relationships as either “just talking” or “not well developed,” as was the case for C6 and C7:

C6: It didn't seem like it was a therapy to deal with such and such until it was resolved. With all of the therapists, it was just going and talking to people. So, it didn't seem like it was ending something, midstream. That's why it never occurred to me to call.

C7: I just quit. And, looking back, I don't think I would do anything different. Because our relationship wasn't set up - it wasn't developed enough - that I would feel comfortable in telling her this. So, I don't think I would do anything different. I feel bad, because she may not have likely known what was going on, and I didn't go back. But, at the same time, I wouldn't have done it differently.

Nonetheless, some clients certainly do choose to communicate their intent to terminate to their therapists, and may do so in a very direct manner, as C3 demonstrated:

C3: I told her, "I will not be coming back, because you don't listen to me." And she got quite put out with me. Well, tough! Sometimes a counsellor doesn't work out for somebody.

However, when clients do choose to communicate their intent to terminate with their therapists, they do not always put forward their true reasons for doing so. As C10 described, clients may not want to risk displeasing their therapists by terminating, and consequently construct "excuses" or even represent that their therapist had 'cured' them, to avoid potential confrontations:

C10: I saw her a few times, and I just basically said, "Thank you. I'm doing all right." Which really wasn't true. So, you know, I didn't outright lie . . . that's the people-pleaser in me. I didn't want to say, "Well, I'm sorry, but you don't know enough about this to help me." I didn't want to do that. So, she couldn't have made a referral, because she didn't think she needed to.

Unsuccessful therapy experiences, whether giving rise to or being defined by the process of ending, have a profound effect on clients' experiences of continuing to become more familiar with the enterprise of therapy and with the thoughts and feelings about continuing to move along their helical path. Many clients are able to tease apart their evaluations of one or more therapy experiences as unsuccessful from their more global evaluations of the enterprise of therapy. As a result, after moving through the ending process, even in the most unpleasant of circumstances, clients envision and



create *continuing segments of their helical path*, which moves them toward future therapy experiences. C6 described her steadfast distinction between ‘an unsuccessful therapy experience’ and ‘therapy as an unsuccessful enterprise,’ in the context of her own needs for getting better:

C3: I'm a big proponent of counselling, and would never let something like an unsuccessful therapy experience put me off. Yes, it would put me off that therapist, but within my own resources, I would never abandon therapy as something to make myself better.

Other clients do not make, or are no longer willing to entertain such a distinction. Such clients have had a sufficiently noxious single unsuccessful therapy experience that they are no longer willing to move further along their helical path, which would necessarily include future therapy attempts, for fear that doing so may bring about more unsuccessful experiences. Nonetheless, there are clients who have had repeated unsuccessful therapy experiences over the course of moving forward along their helical paths, and yet choose to continue to embark upon future courses of therapy.

Endings that are predicated upon, or produce, clients’ feelings of significant disappointment, often relating to their evaluations that they did not have their expectations for therapy met, have the potential to turn clients away from considerations of future therapy. In some cases, as C6 described, clients’ journeys may incorporate periods of “*hibernation*” where they temporarily postpone their decision about whether or not to continue along their path:

C6: I expected that the counsellor would be more spiritual. But, she didn't seem to be. She just seemed confused about what I wanted. So, I was far more disappointed after the second time, and I went into hibernation for a little while.

The type of hibernating demonstrated by C6 is of the “escape” variety. Other clients, however, actively plan to alter their course, at times, to include periods away from the enterprise of therapy to test their abilities to manage life on their own. C9 demonstrated this variety of “hibernating,” which we may better describe as a period of self-examination in the absence of a therapeutic context:

C9: I guess it was about three months went by, with the first individual. I thought, "Well, I should be getting somewhat better by now. Maybe I won't use any more of his time. I'll strike out on my own, and see whether this will carry on through." Because, I suppose, I didn't really know a lot about counselling or therapy, at that time, having never really been under it before. I didn't know what to expect, except that - as I mentioned - my expectations were very high. Exceedingly high. Not knowing what I was treating, and all. And thinking, "Well, I shouldn't have to be doing this forever. One of these days I can see the light, and then I'll carry on well enough on my own."

For some clients, periods of “hibernation” may extend into more permanent moves away from the enterprise of therapy, and may therefore represent the client’s

decision to *abandon the helical path altogether*. This type of shift is represented in Figure 4-1 as a dashed arrow projecting on a tangent away from the smooth turns of the helical path. Clients who make this type of shift have “had enough” of therapy, and may come to rely on and value non-talk therapy, including their internal resources for dealing with their problems, as C5 and C10 demonstrate:

C5: And I went to see some other counsellors involved in meditation, and Chi Kung, and other things on the natural side - not so much on the academic side. I sort of explored that more. And when I joined the Chi Kung group . . . I was trying to work things through like that. And to this day, I’ve never sought any treatment. I’m surviving all right.

C10: After my second unsuccessful therapy experience, I made up my mind, for sure, that I was never going back. And then I would just basically give up on professional help. And that was the last time that I had ever seen any type of counsellor for my eating disorder. And I guess that ended up being a lot of years spent, when I really suffered through the eating disorder, when I really feel like I shouldn't have had to if I would have found someone who could have had the compassion and knowledge to help me along, and really shorten up the journey of the eating disorder. As it was, I guess I really relied on and I pulled through on my inner strengths, and my spirituality is what ended up getting me through it. And healing me to the point where I am today.

Although most clients assign a negative valence to their experiences of unsuccessful therapy, generally, and to the recurrent process of ending experienced as they move along the helical path, more specifically, some clients also recognize that these inherently negative experiences have paradoxically had some positive impact on them, including impacts on the course of their paths. For example, clients who have historically had difficulties in setting boundaries with or seeking the approval of others find that their choice to terminate therapy, even though it has been an unsuccessful experience, is one that represents positive change in their behavioural patterns. C3 demonstrated this dynamic:

C3: I used to be a real pleaser. A total doormat. And it was about that time I had just had it. And I think I was tired of being abused at work. And I was proud of myself for recognizing that I didn't have to please this counsellor, and that I could terminate it. So, in a funny kind of way, it affirmed that I could. And I didn't do it in a nasty way. I just told her what I thought, and left. And I didn't care what she thought. And that was new for me. I didn't need to worry about pleasing her. And so, in some ways, you might say, "ok - there was a positive effect, even if the counsellor hadn't meant that to happen." Because I'm sure she wasn't trying to provoke that kind of behaviour.

Clients use their continually increasing familiarity with the enterprise of therapy, developed over time and concurrent with movement along their helical paths, to guide and shape the future processes inherent in their continuing helical path. C3 went on to

describe how she used her history and experiences of unsuccessful therapy to shape her vision of her future therapy experiences, with implications for future processes of embarking, evaluating and ending:

C3: And I know better, now, what's important to me to get clear with a therapist .

. . I think I'd do a better job with the therapist, because I've done a lot of psychological work - if you want to call it that - on my own.

Affectively, unsuccessful therapy experiences have a profound impact on clients, and a host of negative feelings surface during the Ending process. Feeling like a failure, feeling hopeless, and feeling helpless are the most common affective reactions to unsuccessful therapy, and these feelings do not lift quickly. Further, these affective reactions have great potential to dramatically alter both the content and process of the client's ever-unfolding and emerging helical path, as C10 described:

C10: I felt like a total failure. I thought it was my fault, at that time, because I wasn't thinking clearly. I was so caught up in my own problems, that when I had this experience, I thought, "Well, I really must not be that important." I guess it really lowered my self-esteem, because I thought, "Man, if this psychologist isn't going to pay any attention to me, then who is?" So, it was very detrimental. It just crushed my self-esteem, and as elementary as it sounds, it hurt my feelings. And it also left me feeling really hopeless. Because I thought, I never reached out for help until I felt desperate. They

weren't able to help me. And then I felt that I was just at the bottom, because where do I go now? Like, it really left me feeling like I had nowhere to go, and that there wasn't hope. And it took a long time for that to rebuild.

When the historical helical path includes several unsuccessful therapy experiences, clients may become “terminally bewildered” with respect to therapy and the prospect of staying the course with respect to future processes implicit in their unfolding helical path. Some clients may internalize even a single unsuccessful therapy encounter as a “crazy-making experience,” and may then begin to doubt their ability to be healed, and may even doubt their sanity, as C7 described:

C7: I was questioning myself and my ability to heal after the time that had passed. So, as a client, it seemed like a failure to me, because I hadn't met all my goals. But, I didn't know what else to do. I knew what I was doing wasn't working, but I didn't know where else to go. And I didn't feel comfortable bringing it up with her. And then, with my upbringing that “professionals in authority are right,” then I turned it that I was the person. And that was hard. I remember being scared to go back to her . . . I didn't want to tell her that I wasn't coming back, because I think . . . and this is hard, but . . . I think because I would have been going against authority by not. . . . But then, I was afraid to go back, because of what she had said about [the injury to] my arm. What if she was right? What if I really was crazy?

A single process or experience of ending, within a specific therapeutic encounter, can, however, produce very positive outcomes for a client when considered as one part of a much larger helical path. The process of ending or, for that matter, the entirety of the client's helical path-to-date, has the potential to cultivate a consumer-oriented stance in clients, which they will take forward to their future therapeutic experiences. Each time clients traverse one of the three processes, they become much clearer about what they want from therapy and from their therapists in the future and, perhaps more important, what they do not want.

As C7 and C8 explained, the greater clarity, which, unfortunately, often develops through having one or more unsuccessful therapy experiences, allows clients to embark upon future courses of therapy with a more informed and confident manner. Such a shift has the potential to substantially increase the probability that future therapy will actually be successful:

C7: I think over that time I was also becoming more clear about what I needed from these people, and how to dump people quickly when I wasn't getting my needs met. So, I think the experience with that counsellor certainly kind of pointed me to what I didn't want. Probably I became clearer about what kind of person I wanted to work with. And I was able to pick up very quickly with the next counsellor.

C8: I think you do put yourself in the hands of the therapist a little bit, and that relationship can be abused, or not handled right. And I think it can do damage. And I think that's the unfortunate side, and I don't think people realize that . . . that therapists are very human. And there are some very good ones and some very bad ones out there. And you should shop around, really. You should really - right off the get go - get somebody that you're very comfortable with, and that's very clear what you're there for. And things like that. And I think I had that by the second therapist. I think I was more able to know what to expect, and to know what I wanted out of the sessions.

## **4.2 Summary**

The core category, the Client's Helical Path, is represented by three cyclically-related subcategories, Embarking, Evaluating, and Ending, and a fourth subcategory, Familiarity, which represents the changes in clients over time that become manifest within the first three subcategories. The Client's Helical Path is a theory that contextualizes clients' experiences of unsuccessful therapy at the level of the client, rather than at the level of the course of therapy. It is a theory that explains the multiple therapy experiences of clients, and provides an understanding of how, from the perspective of clients, their past therapy experiences influence future ones.

Familiarity, representing clients' movement over time from being novice clients to more experienced ones, has properties of experience and understanding. Embarking represents the process in which clients first become engaged as they begin a new course of therapy, and has properties of desires, feelings, and communication. Evaluating



represents a subsequent process in which clients adjudicate their satisfaction, and has properties of laying blame and contextualizing. Ending represents the final process within a course of therapy at which time clients exit from a specific course of therapy, and has properties of means and shifts.

## **CHAPTER FIVE:**

### **EXERCISES IN SELF-SCRUTINY**

#### **5.1 Evaluation based on Glaser (1992)**

As outlined in Chapter Two, Glaser (1992) proposed that solid, scientifically-inducted theories must be parsimonious while still having sufficient scope; the theory must account for as much behavioural variability as possible with the least number of theoretical elements. The current theory, the Client's Helical Path, purports to account for the variability in the behaviour of clients who have had unsuccessful therapy experiences. Importantly, the temporal scope of behavioural variability accounted for by this theory is not limited to a single course of therapy. Rather, the theory presents an understanding of client behaviour over multiple therapy experiences, including the way in which behaviour found in one therapy experience implicates behaviour in the next.

Further, the theory accounts for core processes related to unsuccessful therapy within each course of therapy. With respect to theoretical elements, there are four: the three cyclically-related process categories and the single temporal/experiential category. A three-dimensional helical structure that is not cumbersome yet, in my opinion, is sufficiently sophisticated, graphically represents the associations among categories.

Glaser (1992) also suggested four specific criteria that theories claiming to have demonstrable 'merit' must meet. I have adjudicated the theory generated through the current study with respect to each of the criteria proposed by Glaser, and the returns

from this evaluation are presented in Table 5-1. It is my conclusion that the present theory, the Client's Helical Path, meets Glaser's criteria of Fit, Work, Relevance, and Modifiability.

**Table 5-1**

**Evaluation of theory per Glaser (1992)**

CRITERION	EVALUATION
<p style="text-align: center;"><b><u>Fit</u></b></p> <p><i>[the consonance between the grounded theory and the phenomenon as understood by the participants and other researchers in the content area.]</i></p>	<ul style="list-style-type: none"> <li>• Although I have not received responses from the research participants, responses from current clients in my clinical practice have been highly affirming of the validity of the theory. Moreover, clients have indicated that they feel validated and listened to when this theory is presented to them in the first session as a means of exploring their expectations for our work together.</li> <li>• Past and present colleagues (including psychologists, psychiatrists, and social workers) have indicated that the theory makes intuitive sense to them. Several colleagues have begun to pay more attention to past therapy experiences of their clients, in the context of implications for current therapeutic work.</li> </ul>
<p style="text-align: center;"><b><u>Work</u></b></p>	<ul style="list-style-type: none"> <li>• The primary concerns expressed by participants were</li> </ul>

CRITERION	EVALUATION
<p><i>[the ability of the theory to explain the major variations of behaviour in the content area, in the context of the primary concerns expressed by the participants.]</i></p>	<p>that:</p> <ul style="list-style-type: none"> <li>• (1) they have found themselves traveling along an extended, twisting path that encompasses multiple therapy experiences;</li> <li>• (2) they entered each course of therapy with certain expectations for what would unfold;</li> <li>• (3) based on these expectations, they evaluated their therapy experiences as unsuccessful;</li> <li>• (4) based on these evaluations, their therapy experiences were terminated; and</li> <li>• (5) they find themselves wishing that they “knew then what they know now,” revealing that as they travel along their paths, they become more familiar with the enterprise of therapy, and such familiarity shapes future therapy experiences.</li> <li>• The three cyclically-related process categories and the single temporal/experiential category are related in a helical fashion, and thus the theory as a whole incorporates and represents the primary concerns expressed by participants.</li> </ul>
<p><b><u>Relevance</u></b></p>	

CRITERION	EVALUATION
<i>[achieved when the theory both fits and works.]</i>	<ul style="list-style-type: none"> <li>• Based on my proposition that the theory both fits and works, by definition, it meets the criterion of relevance.</li> </ul>
<p><b><u>Modifiability</u></b></p> <p><i>[the theory is not to be ‘written in stone’ and should be modifiable, to accommodate new data that suggest a need for variations in the structure of the theory.]</i></p>	<ul style="list-style-type: none"> <li>• I designed the helical structure used to represent the Client’s Helical Path to be able to accommodate revisions, substitutions, and additions to the (currently) three cyclically related process categories.</li> <li>• I wrote descriptions of each of the process categories and, indeed, even the category that provides the temporal/experiential dimension, in a manner that is conducive to modification based on and required by new data.</li> </ul>

## 5.2 Evaluation based on Elliott, Fischer, and Rennie (1999)

Predicated upon the significant increase in researchers’ use of qualitative research methods in the late 1990s, Elliott, Fischer, and Rennie (1999) have identified

and have fulfilled the need to develop a set of publishability guidelines<sup>16</sup> to provide guidance to individuals responsible for psychology journals (e.g., editors, reviewers) and for overseeing graduate student research, with respect to their review and adjudication of manuscripts reporting qualitative research. It is the position of these authors that we must use the definition and underlying philosophy of the qualitative paradigm to develop a consonant set of guidelines, or criteria, against which we may evaluate qualitative research. Nonetheless, Elliott et al. do not put forward these guidelines as the only ones against which we should judge qualitative research.

Notwithstanding their shared view with respect to the need for, and utility of, such guidelines, the authors also provided a disclaimer that they do not necessarily agree with one another about “the complex philosophical issues involved or the scientific methods used in qualitative research” (Elliott et al., 1999, p. 216). Their diverging philosophical positions, which they acknowledge, become particularly apparent in the heterogeneous set of methods that they suggest researchers may use to satisfy the criterion of “providing credibility checks” (see Table 5-2). Some qualitative researchers may find the entire set of methods acceptable and consonant with their philosophical assumptions, while others may only adopt a subset of these methods. I fall in with the latter group.

I have evaluated my current research against each of the criteria that Elliott et al. (1999) identified as particularly important for qualitative research. I do so in an effort to

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<sup>16</sup> Elliott, Fischer, and Rennie (1999) granted explicit permission in their article for others to reproduce their publishability guidelines for non-commercial use.

demonstrate my interest in reflexivity and self-scrutiny, and to provide yet another framework (in addition to that proposed by Glaser, 1992) for others to draw their own conclusions about the quality of my current work. The returns from my self-evaluation against these criteria are presented in Table 5-2.

**Table 5-2**

**Evaluation of theory per Elliott, Fischer, and Rennie (1999)**

<b>GUIDELINES <i>ESPECIALLY</i> PERTINENT TO QUALITATIVE RESEARCH</b>	
<b>GUIDELINE</b>	<b>EVALUATION</b>
<p><b><u><i>Owning one's perspective</i></u></b></p> <p><i>Authors specify their theoretical orientations and personal anticipations, both as known in advance and as they became apparent during the research. In developing and communicating their understanding of the phenomenon under study, authors attempt to recognize their values, interests, and assumptions and the role these play in the understandings. This disclosure of values and assumptions helps readers to interpret the researchers' data and understanding of them, and to</i></p>	<ul style="list-style-type: none"> <li>• I have explicitly provided the following personal information to readers, in an effort to "own my perspective":</li> <li>• (1) Philosophical assumptions (Sec. 1.3.2);</li> <li>• (2) Research history (Sec. 1.3.3);</li> <li>• (3) Clinical history (Sec. 1.3.4);</li> <li>• (4) Assumptions, biases, and hypotheses (Sec. 1.3.5);</li> <li>• (5) Chronological (and virtually unedited) entries from my research process journal (Sec. 3.4); and</li> </ul>

GUIDELINES <i>ESPECIALLY</i> PERTINENT TO QUALITATIVE RESEARCH	
GUIDELINE	EVALUATION
<i>consider possible alternatives.</i>	<ul style="list-style-type: none"> <li>• (6) A complete account of all questions and prompts used in the research interviews (Table 5-3)</li> </ul>
<p><b><u>Situating the sample</u></b></p> <p><i>Authors describe the research participants and their life circumstances to aid the reader in judging the range of people and situations to which the findings might be relevant.</i></p>	<ul style="list-style-type: none"> <li>• Sec. 3.2.1 describes the process of recruiting participants</li> <li>• Sec. 3.2.2 describes the sample of participants that I interviewed</li> </ul>
<p><b><u>Ground in examples</u></b></p> <p><i>Authors provide examples of the data to illustrate both the analytic procedures used in the study and the understanding developed in the light of them.</i></p> <p><i>The examples allow appraisal of the fit between the data and the authors' understanding of them; they also allow readers to conceptualize possible alternative meanings and understandings.</i></p>	<ul style="list-style-type: none"> <li>• I have presented a large volume of interview data throughout Chapter Four. Not only is this an attempt to rectify the aforementioned disparity in the literature, but it also reflects my belief that the eloquent voices of clients provide rich illustrations of the concepts being discussed.</li> </ul>



GUIDELINES <i>ESPECIALLY</i> PERTINENT TO QUALITATIVE RESEARCH	
GUIDELINE	EVALUATION
<p><b><u>Providing credibility checks</u></b></p> <p><i>Researchers may use any one of several methods for checking the credibility of their categories, themes, or accounts.</i></p> <p><i>Where relevant, these may include:</i></p> <p><i>(a) checking these understandings with the original informants or others similar to them;</i></p> <p><i>(b) using multiple qualitative analysts, an additional analytic ‘auditor,’ or the original analyst for a ‘verification step’ of reviewing the data for discrepancies, overstatements, or errors;</i></p> <p><i>(c) comparing two or more varied qualitative perspectives, or</i></p> <p><i>(d) where appropriate, ‘triangulation’ with external factors (e.g., outcome or recovery) or quantitative data.</i></p>	<ul style="list-style-type: none"> <li>• I checked the credibility of the categories and the theory, as a whole, by soliciting feedback from colleagues and clients, with respect to both the parts and whole of the theory.</li> <li>• My research process journal documents several points at which I chose to start the analysis anew, due to concerns that I had not been working with the data in a manner that was true to the methodological underpinnings.</li> <li>• Table 5-3 documents my analysis of the degree to which the emerging theory guided my activity in the research interviews (i.e., the use of various probes and questions).</li> <li>• Each participant reviewed the transcript of our interview to identify</li> </ul>

GUIDELINES <i>ESPECIALLY</i> PERTINENT TO QUALITATIVE RESEARCH	
GUIDELINE	EVALUATION
	any errors or omissions, and to ensure that what they said was what they meant to say.
<p style="text-align: center;"><b><u>Coherence</u></b></p> <p><i>The understanding is represented in a way that achieves coherence and integration while preserving nuances in the data.</i></p> <p><i>The understanding fits together to form a data-based story/narrative, ‘map,’ framework, or underlying structure for the phenomenon or domain.</i></p>	<ul style="list-style-type: none"> <li>• Achieving a coherent presentation of the methodology, the method, the data, and the theory that I produced has been a challenge of the like I have not previously encountered. Perhaps such coherence will be easier to achieve once I develop greater skill and efficiency in working with a grounded theory methodology.</li> <li>• Nonetheless, I employed several strategies in an effort to make a coherent presentation, including:</li> <li>• (1) the use of various figures to represent (evolving) understandings and associations among the categories;</li> </ul>

GUIDELINES <i>ESPECIALLY</i> PERTINENT TO QUALITATIVE RESEARCH	
GUIDELINE	EVALUATION
	<ul style="list-style-type: none"> <li>• (2) a logical ordering and frequent cross-referencing of the components of the theory, in the narrative presentation.</li> </ul>
<p><b><u>Accomplishing general vs. specific research tasks</u></b></p> <p><i>Where a general understanding of the phenomenon is intended, it is based on an appropriate range of instances (informants or situations). Limitations of extending the findings to other contexts and informants are specified.</i></p> <p><i>Where understanding a specific instance or case is the goal, it has been studied and described systematically and comprehensively enough to provide the reader a basis for attaining that understanding. Such case studies also address limitations of extending the findings to other instances.</i></p>	<ul style="list-style-type: none"> <li>• The current study intended to produce a general understanding of clients' experience of unsuccessful therapy.</li> <li>• To this end, all respondents (<math>N = 18</math>) to recruitment advertisements published in a Western Canadian urban center were contacted, and I interviewed all of those who met the minimum eligibility criteria (<math>N = 11</math>).</li> <li>• After performing in-depth analysis of the data from the first 8 interviews, no new categories emerged. Hence, I achieved theoretical saturation. I analyzed the remaining interview protocols (i.e., coded to categories) to</li> </ul>

GUIDELINES <i>ESPECIALLY</i> PERTINENT TO QUALITATIVE RESEARCH	
GUIDELINE	EVALUATION
	<p>ensure all category exemplars (including those from the final protocols) were considered for inclusion in the final write-up of the theory.</p> <ul style="list-style-type: none"> <li>• I have laid out limitations with respect to extending the findings to other contexts and informants in Chapter 6.</li> </ul>
<p><b><u>Resonating with readers</u></b></p> <p><i>The manuscript stimulates resonance in readers/reviewers, meaning that the material is presented in such a way that readers/reviewers, taking all other guidelines into account, judge it to have represented accurately the subject matter or to have clarified or expanded their appreciation and understanding of it.</i></p>	<ul style="list-style-type: none"> <li>• Creating a product that will resonate with readers has been a primary goal since the inception of this research project.</li> <li>• It is difficult to evaluate the degree to which the final product will, however, resonate with readers. I will eagerly await that adjudication.</li> </ul>

### **5.3 Evaluation of Category-Question Concordance**

According to the grounded theory methodology, data collection should proceed guided by the emerging theory. Often, or at least ideally, such theoretical sampling takes the form of the emerging theory guiding the researcher to sample from new sources of data, in terms of different individuals or settings. In the current study, the entire population of “clients who reported having unsuccessful therapy experiences and who responded to recruitment advertisements” was considered for participation in the study. Of this population, I interviewed all individuals who met the minimum eligibility criteria. Thus, I suggest that I explored all reasonably accessible sources of data, in terms of available individuals, and that I included all available individuals in the study who met the basic inclusion and exclusion criteria.

However, in an effort to stay true to the theoretical intent and purpose of theoretical sampling, which forms an integral part of the grounded theory methodology, I made a concerted effort to ensure that the emerging theory did, in fact, influence the particular data that I gleaned through the research interview. So, although the emerging theory did not guide whom I interviewed, it did guide the content of questions and prompts that I used during subsequent interviews. After each interview, I made notes about the content of the discussion, and I employed the constant comparative method to compare the new data with those from previous interviews. This process shaped the categories and relations among them, which were emerging and, hence, shaped the conceptualization of the emerging theory.

As I conducted each subsequent interview, I was cognizant of the elements of the emerging theory, and this guided the domains of client information into which I

attempted to tap. Importantly, the guiding theory did not dictate the types of questions that I asked or prompts that I used. All interviews were open-ended in nature, and all interviews began with one of the basic primary- or secondary-level prompts (see Table 3-1). The conceptualization of the emerging theory merely provided content material for the somewhat more focused questions used in latter interviews, which is consistent with the grounded theory methodology as described by both Glaser and Strauss (1967) and Rennie (1995b).

Table 5-3 presents the returns from an analysis I prepared of the concordance between the categories emerging from one interview (built upon the data collected and continually-evolving conceptualization of the emerging theory from previous interviews) with the questions and prompts that I used in the subsequent interview. For example, the reader can scrutinize the concordance between the categories emerging from (i.e., after) Interview #3 with the questions and prompts I used in Interview #4. I believe there is a high degree of concordance, which provides yet another credibility check to assist readers in making evaluations about the quality of this research. I should note that, in Table 5-3, I have made reference to all questions and prompts from each interview. This provides the reader with additional information (beyond the concordance analysis) about the content, style, and volume of interviewer activity in the research interviews. Note, for example, in Interview #1 my very limited and constricted activity, as the interviewer, which is consistent with the need for earlier interviews to be as open-ended and free-flowing as possible, in order to avoid unduly shaping the type and style of information provided by the interviewee.

**Table 5-3**

**Evaluation of category-question concordance**

<b>Interview # 1</b>	
<b>Questions/Prompts</b>	<b>Emerging Categories</b>
<ul style="list-style-type: none"> <li>• Tell me about your experience of unsuccessful therapy.</li> <li>• What was it that made the therapy unsuccessful?</li> </ul>	<ul style="list-style-type: none"> <li>• type of therapy</li> <li>• expected outcome</li> <li>• actual outcome</li> <li>• client attribution for UT - re therapist</li> <li>• client perseverance</li> <li>• changes in dynamics of therapist-client relationship</li> <li>• impact of unsuccessful therapy</li> </ul>

<b>Interview # 2</b>	
<b>Questions/Prompts</b>	<b>Emerging Categories</b>
<ul style="list-style-type: none"> <li>• Tell me about your experience or experiences of unsuccessful therapy.</li> <li>• What was the consequence for you, of having had that particular unsuccessful experience?</li> <li>• Did that bring to an end that working relationship?</li> </ul>	<ul style="list-style-type: none"> <li>• multiple therapeutic experiences</li> <li>• client identification of central problem</li> <li>• client view of therapists in general</li> <li>• consequences of unsuccessful therapy</li> <li>• problems related to unsuccessful therapy</li> <li>• therapist-client boundaries</li> <li>• consequences of multiple unsuccessful</li> </ul>

Interview # 2	
Questions/Prompts	Emerging Categories
<ul style="list-style-type: none"> <li>• What was it like for you to have a couple of unsuccessful experiences, then a successful one, then one that started out successful, but turned out unsuccessful?</li> </ul>	<p>therapies</p> <ul style="list-style-type: none"> <li>• therapist-client communication</li> <li>• lack of fit between client and therapy</li> <li>• problematic therapist-client communication</li> <li>• therapist's own issues related to unsuccessful therapy</li> </ul>

Interview # 3	
Questions/Prompts	Emerging Categories
<ul style="list-style-type: none"> <li>• By virtue of you being here, I know that you have some sort of unsuccessful therapy experience, and I'd just like you to tell me about it.</li> <li>• What was the consequence? What impact did that have on your life - having had that unsuccessful experience at that time.</li> </ul>	<ul style="list-style-type: none"> <li>• therapist-client differences re etiology of client's problem(s)</li> <li>• previous therapeutic experiences related to current/future expectations of therapy</li> <li>• client perspective on therapy in general</li> <li>• reason for therapy being unsuccessful is focus of therapy</li> <li>• attributions for unsuccessful therapy</li> </ul>



Interview # 3	
Questions/Prompts	Emerging Categories
<ul style="list-style-type: none"> <li>• What was your mind set, now, of having had a successful experience, an unsuccessful experience, and now you're about to embark on this new experience with this new person . . . what was your mind set entering that?</li> <li>• After these several experiences, some successful and some unsuccessful, do you have a sense of what makes therapy successful or unsuccessful?</li> <li>• What was it about those experiences that made them unsuccessful?</li> <li>• Was there any element of negotiating, or trying to get on the same page, or trying to understand where each other is coming from?</li> </ul>	<ul style="list-style-type: none"> <li>• implicit rules of therapy/therapist</li> <li>• therapist-client communication</li> <li>• impact on client of terminating therapy</li> <li>• therapist-client differences re interpretation of client's history</li> <li>• therapist-client differences re understanding the client's problem</li> <li>• client resolutions/advice after experiencing unsuccessful therapy</li> <li>• explicitly addressing client-therapist fit related to successful therapy</li> </ul>

Interview # 4	
Questions/Prompts	Emerging Categories
<ul style="list-style-type: none"> <li>• Tell me about your unsuccessful therapy experience.</li> <li>• What were you hoping to get out of it?</li> <li>• What was it about it that you would consider unsuccessful?</li> <li>• What were your expectations going in there?</li> <li>• Did you talk to the counsellor about what you were looking for?</li> <li>• What kind of things would have made it more successful?</li> <li>• What was the impact of having that unsuccessful therapy experience, if any?</li> <li>• How likely would you have been to go back and access those services again?</li> </ul>	<ul style="list-style-type: none"> <li>• client perception of therapist as friend</li> <li>• discrepancy between expectations for therapy and actual experience</li> <li>• positive qualities of the therapist</li> <li>• discussion of client's expectations</li> <li>• problems with therapist re therapist's level of activity</li> <li>• client unfamiliarity with the therapy 'system'</li> </ul>

Interview # 5	
Questions/Prompts	Emerging Categories
<ul style="list-style-type: none"> <li>• Tell me about whatever unsuccessful experience or experiences you've had with therapy.</li> <li>• What kind of expectations did you have - if any . . . or, what was your mind set going into that?</li> <li>• What impact did that have on your life? Right at the moment that you walked out the door; also in the days and weeks and months since then.</li> </ul>	<ul style="list-style-type: none"> <li>• client perception of therapist-client fit/relationship</li> <li>• client explicitly states needs/expectations re therapy</li> <li>• client confusion re needs for therapy</li> <li>• therapist referring/rejecting client</li> <li>• client confusion re referral/rejection by therapist</li> <li>• consequences for client re referral/rejection by therapist</li> </ul>

Interview # 6	
Questions/Prompts	Emerging Categories
<ul style="list-style-type: none"> <li>• Tell me about your unsuccessful therapy experience or experiences.</li> <li>• Before you started that therapy, what were your expectations?</li> <li>• How was that sorted out through the</li> </ul>	<ul style="list-style-type: none"> <li>• client's contrasting of therapy with other supports related to unsuccessful therapy</li> <li>• client's cost/benefit analysis re therapy</li> <li>• client's confusion re cause of unsuccessful therapy</li> </ul>

Interview # 6	
Questions/Prompts	Emerging Categories
<p>therapy, what your expectations were?</p> <ul style="list-style-type: none"> <li>• Can you tell me a bit more about what made that experience unsuccessful?</li> <li>• Has your thinking about that experience changed because you now have these other experiences to compare and contrast it with?</li> <li>• You said that you noticed this after the first couple of sessions. And how long did you continue with that therapy?</li> <li>• What else can you tell me about what impact having that unsuccessful experience had on your life?</li> <li>• You decided to try again. How soon after did you pick up with the second counsellor?</li> <li>• Do you see in retrospect, or do you</li> </ul>	<ul style="list-style-type: none"> <li>• client-therapist ‘just talking’ related to unsuccessful therapy</li> <li>• lack of therapy structure related to unsuccessful therapy</li> <li>• client evaluation that costs exceed benefits related to unsuccessful therapy</li> <li>• necessary but insufficient qualities of therapist</li> <li>• client’s contrast of professional re non-professional help re degree of burden on other</li> <li>• tangible outcomes related to successful therapy</li> <li>• therapist qualities related to unsuccessful therapy</li> <li>• chaotic therapy process related to unsuccessful therapy</li> <li>• client’s comfort with therapy related to successful therapy</li> <li>• demeanor of therapist related to client’s</li> </ul>

Interview # 6	
Questions/Prompts	Emerging Categories
<p>recall thinking or feeling at the time, that the previous unsuccessful experience was influencing how you were approaching the counselling?</p> <ul style="list-style-type: none"> <li>• What transpired to make that connection with the therapist, or not make a connection?</li> <li>• How was it sorted out that therapy would end?</li> <li>• Within a relatively short time frame, you've had two unsuccessful therapy experiences. What are you thinking or feeling about therapy, about yourself, about therapist . . . about anything related to therapy, at that point?</li> <li>• Where is your head and your heart as you're walking into the third counselling experience?</li> <li>• Any other differences than a</li> </ul>	<p>comfort with therapy</p> <ul style="list-style-type: none"> <li>• client's clarity re own needs for therapy increases with more experiences</li> <li>• client attributions for unsuccessful therapy</li> <li>• client's decreased confidence in therapist related to unsuccessful therapy</li> <li>• client not being understood related to unsuccessful therapy</li> <li>• client's means of terminating therapy</li> <li>• consequences for client of having had unsuccessful therapy</li> <li>• client's perspective on therapy in general related to successfulness of therapy</li> <li>• potential benefits for client re unsuccessful therapy: allow comparing/contrasting of therapists</li> <li>• clients' experience a learning curve re understanding of therapy/therapists</li> <li>• client-therapist knowledge gap narrows</li> </ul>

Interview # 6	
Questions/Prompts	Emerging Categories
<p>friendship?</p> <ul style="list-style-type: none"> <li>• What was it you observed or experienced that let you know that #1 was not comfortable being herself?</li> <li>• Was there some comparison among therapists going on there?</li> <li>• What are you thinking about that therapy - that particular therapeutic relationship - and just therapy in general . . . once it starts going well?</li> <li>• How would you capture why it ended?</li> <li>• You stop going there, and what are you feeling now, or thinking now . . . at that point?</li> </ul>	<p>with more therapy experiences</p> <ul style="list-style-type: none"> <li>• client experiences negative feelings due to unsuccessful therapy</li> <li>• client behavioural reactions/responses to unsuccessful therapy</li> <li>• client's multiple therapy experiences constitute a 'therapy journey'</li> <li>• client and therapist understanding one another</li> <li>• critical incidents in therapy related to unsuccessful therapy</li> <li>• therapist-client disconnection after being connection</li> <li>• therapist-client always being disconnected</li> <li>• client reasons for terminating therapy in a particular manner</li> <li>• client's view on therapy in general related to their journey across therapies</li> <li>• consequences for client of having</li> </ul>

Interview # 6	
Questions/Prompts	Emerging Categories
	<p>experienced unsuccessful therapy</p> <ul style="list-style-type: none"> <li>• impact of previous unsuccessful therapy on new therapy experience</li> </ul>

Interview # 7	
Questions/Prompts	Emerging Categories
<ul style="list-style-type: none"> <li>• Tell me about your unsuccessful therapy experience or experiences.</li> <li>• What expectations did you have of therapy?</li> <li>• At what point did you decide - evaluate for yourself - that this was unsuccessful therapy?</li> <li>• “This therapy was unsuccessful because _____,” and fill in that sentence.</li> <li>• Did you tell her that you weren’t coming back, or did you not come back?</li> <li>• What impact did having had that</li> </ul>	<ul style="list-style-type: none"> <li>• client development - the novice ‘stage’</li> <li>• client expectations for what therapy would offer</li> <li>• clients not knowing the rules of therapy</li> <li>• process of clients becoming experienced/acclimated to the world of therapy</li> <li>• client’s retrospective (if I had my time over again) thoughts on their choices/behaviours</li> <li>• client uncertainty whether therapy successful or unsuccessful</li> <li>• contrast of client perspective: then with now</li> </ul>

Interview # 7	
Questions/Prompts	Emerging Categories
<p>unsuccessful therapy experience have on you?</p> <ul style="list-style-type: none"> <li>• Are there any dominant features of that experience that really . . . that's what made it unsuccessful?</li> <li>• Did you notice at the time that having had that previous unsuccessful experience was having some impact on what your mind set was, or feelings were, as you entered that second therapy?</li> <li>• Having had now another unsuccessful therapy experience . . . any impact that had on you?</li> <li>• How did you come to know that that was the way this operated and didn't operate?</li> <li>• What, if any, bearing did that have on how you were evaluating the successfulness or unsuccessfulness</li> </ul>	<ul style="list-style-type: none"> <li>• client's experience of choosing to terminate therapy</li> <li>• consequences for client of unsuccessful therapy years later</li> <li>• client's attributions re therapist for unsuccessful therapy</li> <li>• therapist-client discrepancy re why client is seeking therapy</li> <li>• client's learning/journey re therapy - understanding what is not wanted in future therapy</li> <li>• client's learning/journey re therapy - understanding what is wanted in future therapy</li> <li>• influence of therapist's agenda on client's agenda re power differential?</li> <li>• client's difficulty classifying therapy as successful or unsuccessful</li> <li>• client understanding of a previous therapy experience develops/evolves</li> </ul>



Interview # 7	
Questions/Prompts	Emerging Categories
<p>of the therapy - at the time?</p> <ul style="list-style-type: none"> <li>• What impact did that have . . . going to therapy and feeling that there was some sort of discrepancy or gap?</li> <li>• Do you recall there being a point at which you said, “No. I am not going back there”?</li> <li>• What was that like for you to make that decision?</li> <li>• What is it that you’re thinking and feeling as you go forward to work with this new person, in the context of having had these three unsuccessful therapeutic experiences, . . . ?</li> </ul>	<p>over time</p> <ul style="list-style-type: none"> <li>• turning point in therapy: successful to unsuccessful</li> <li>• client’s response to critical moment in therapy - to continue or terminate</li> <li>• client’s emotional response to having terminated therapy</li> <li>• therapist behaviours related to unsuccessful therapy</li> <li>• therapy setting related to unsuccessful therapy</li> <li>• client’s therapy journey related to increased sense of power/control developed over time</li> <li>• client’s therapy journey encompasses client’s changing approach to therapy</li> </ul>

Interview # 8	
Questions/Prompts	Emerging Categories
<ul style="list-style-type: none"> <li>• Tell me about your unsuccessful therapy experience or experiences.</li> <li>• Before you even got to the office for that first session, what was it that you had going in, as far as your own set of expectations, or needs, or wants?</li> <li>• What ideas did you have about what would happen in the therapy?</li> <li>• Was there ever a point where you were feeling this was successful therapy?</li> <li>• Can you tell me a bit more about that turning point?</li> <li>• Did you ever express some of your thoughts that maybe something was wrong with the therapy to the therapist?</li> <li>• Was there anything that she could</li> </ul>	<ul style="list-style-type: none"> <li>• client journey within a given therapy</li> <li>• client journey across several therapies</li> <li>• client attributions for unsuccessful therapy re therapist level of training</li> <li>• therapist-client collusion related to unsuccessful therapy</li> <li>• client expressing dissatisfaction with therapy to therapist</li> <li>• therapist's reaction to hearing client's dissatisfaction with therapy</li> <li>• lack of client-therapist fit related to unsuccessful therapy</li> <li>• client attributions for unsuccessful therapy re client (taking responsibility)</li> <li>• client questioning 'who is to blame' for unsuccessful therapy</li> <li>• lack of therapist-client fit re defining/understanding the client's problem</li> </ul>

Interview # 8	
Questions/Prompts	Emerging Categories
<p>have done in that session, to salvage your working relationship together?</p> <ul style="list-style-type: none"> <li>• You were commenting on how therapy is kind of a risky venture.</li> <li>• Immediately after you terminated, how were you feeling and what were you thinking at that time about having just had this unsuccessful course of therapy?</li> <li>• How were you feeling about trying this again? Now that you're no longer a novice.</li> <li>• How did those feelings of apprehension manifest in how you went about walking in there the first time, and meeting with this new fellow?</li> <li>• If you understood that when you went in to see that first therapist, do you think things would have gone</li> </ul>	<ul style="list-style-type: none"> <li>• therapist's agenda related to unsuccessful therapy</li> <li>• contrast between client's expectations for and actual experience of therapy</li> <li>• turning point in therapy – client becomes protective of therapist</li> <li>• therapist as professional has more power than client</li> <li>• client puts therapist up on pedestal</li> <li>• client exonerates therapist for 'blame' re unsuccessful therapy due to therapist's status</li> <li>• client 'blame-sharing' with therapist re unsuccessful therapy</li> <li>• therapist and client addressing problems about therapy</li> <li>• client perspective on how therapist-client relationship could have been repaired</li> <li>• client perception of therapy in general - a risky enterprise</li> </ul>

Interview # 8	
Questions/Prompts	Emerging Categories
any differently over those eleven session?	<ul style="list-style-type: none"> <li>• client's status as novice related to therapy being risky</li> <li>• riskiness of therapy analogous to investing??</li> <li>• client-while-novice expectations of therapist</li> <li>• client perceiving self as vulnerable and 'at risk' in therapy</li> <li>• client's suggestions/advice for other clients</li> <li>• consequences for client of unsuccessful therapy – feelings</li> <li>• consequences for client of unsuccessful therapy - re future therapy</li> <li>• client journey - revising approach to therapy over time</li> <li>• client experience helpful to therapist re understanding needs of client</li> <li>• client retrospective analysis of what would do differently if had time over</li> </ul>

Interview # 8	
Questions/Prompts	Emerging Categories
	<ul style="list-style-type: none"> <li>• client wisdom/advice for others</li> </ul>

Interview # 9	
Questions/Prompts	Emerging Categories
<ul style="list-style-type: none"> <li>• Tell me about your unsuccessful therapy experience.</li> <li>• What kind of expectations did you have, the first time you went to a counsellor?</li> <li>• Is it fair to say that at the point you ended it, you hadn't really evaluated it as unsuccessful?</li> <li>• Do you think there was anything that could have happened differently within those sessions that would have left you feeling that it was a bit more successful?</li> <li>• In what ways - or not - were your expectations communicated to the</li> </ul>	<ul style="list-style-type: none"> <li>• client exonerates therapy/therapist for unsuccessful therapy</li> <li>• client internalizes blame for unsuccessful therapy</li> <li>• due to depression?</li> <li>• client perspective on degree to which therapist is understanding</li> <li>• client uncertainty about therapist background re how well therapist is understanding client</li> <li>• client's expectations for utility of therapy - could never be enough</li> <li>• client's retrospective analysis of their expectations for therapy – unrealistic</li> <li>• client's perception of therapy as</li> </ul>

Interview # 9	
Questions/Prompts	Emerging Categories
<p>therapist, or did the therapist try to understand your expectations? Do you feel that you and the therapist were on the same page?</p>	<p>successful/unsuccessful related to fluctuating mood</p> <ul style="list-style-type: none"> <li>• consequences of unsuccessful therapy for client - changed perspective on utility of therapy</li> <li>• consequences of unsuccessful therapy for client - more disappointed in self than therapist</li> <li>• unsuccessful therapy related to process of therapy - how information exchanged</li> <li>• client's unmet expectations for therapy - wanting a pat on the back</li> <li>• client not sharing expectations with therapist</li> </ul>

Interview # 10	
Questions/Prompts	Emerging Categories
<ul style="list-style-type: none"> <li>• Tell me about your unsuccessful therapy experience or experiences.</li> <li>• What expectations did you have that very first time when you first reached out?</li> <li>• What impact did having had that unsuccessful experience have on you?</li> <li>• What was your mind set, going back there again to this place where you had already had this unsuccessful therapy experience?</li> <li>• What now was the impact after having two unsuccessful therapy experiences?</li> <li>• I'm wondering what that was like for you, to have him forcing your experience to be seen through his lenses.</li> </ul>	<ul style="list-style-type: none"> <li>• client's pre-therapy/novice stage feelings re upcoming therapy</li> <li>• client's perception of therapy in general – stigma</li> <li>• therapist's damaging implicit messages related to unsuccessful therapy</li> <li>• reasons for no connection being made between therapist and client</li> <li>• pivotal moments in therapy related to unsuccessful therapy – examples</li> <li>• client attributions unsuccessful therapy – therapist's style, approach, lack of respect</li> <li>• client's definition of unsuccessful therapy – not necessarily related to efficacy</li> <li>• increased risk of therapy for client - client vulnerable and has significant need</li> </ul>

Interview # 10	
Questions/Prompts	Emerging Categories
<ul style="list-style-type: none"> <li>• That feeling of disconnection seems to be really a hallmark of many of these experiences. Am I interpreting that, or understanding that correctly?</li> <li>• It seems you're describing that there's kind of a critical period at the beginning of the course of therapy, where that kind of confidence can be instilled in the client. The way you're describing it, it sounds very much like a "make it or break it" situation.</li> <li>• Some people have used the word "safety." And I'm just wondering how that fits for you.</li> <li>• Did you let her know that you wouldn't be coming back?</li> <li>• Is there any way that it would have been possible to maybe rehabilitate any one of those relationships?</li> </ul>	<ul style="list-style-type: none"> <li>• consequences of unsuccessful therapy on expectation when entering new therapy – journey</li> <li>• therapist style related to unsuccessful therapy</li> <li>• explicit acts of therapist related to unsuccessful therapy</li> <li>• consequences for client of unsuccessful therapy - terminating and not returning</li> <li>• elements of therapy environment related to unsuccessful therapy - e.g. receptionist</li> <li>• lack of client-therapist fit re therapist's style related to unsuccessful therapy</li> <li>• therapist's agenda/way of understanding client related to unsuccessful therapy</li> <li>• therapist forcing client to fit with his way of understanding related to unsuccessful therapy</li> <li>• therapist's lack of knowledge re problem</li> </ul>



Interview # 10	
Questions/Prompts	Emerging Categories
<ul style="list-style-type: none"> <li>• At any time did your expectations for therapy get put on the table? Did you ever decide to put them on the table? Or were you ever invited to by any of these therapists?</li> <li>• Do you think there is therapy out there that could work for you?</li> </ul>	<p>content areas related to unsuccessful therapy</p> <ul style="list-style-type: none"> <li>• client's retrospective analysis of needs from therapy</li> <li>• continuum of client knowledge/comfort/experience of therapy process - novice to experienced</li> <li>• client's retrospective analysis re expectations of therapy</li> <li>• consequences for client of unsuccessful therapy – feelings</li> <li>• client's vulnerability and need for help related to therapy being risky for client</li> <li>• changes in client's approach to therapy when no longer novice</li> <li>• consequences of unsuccessful therapy for client different at different points along journey</li> <li>• client's distribution of blame for unsuccessful therapy – different as</li> </ul>

Interview # 10	
Questions/Prompts	Emerging Categories
	<p>journey progresses</p> <ul style="list-style-type: none"> <li>• client's style of terminating therapy</li> <li>• therapist forcing client's story to fit therapist's assumptions related to unsuccessful therapy</li> <li>• client's perspective on what is necessary for therapy to be successful</li> <li>• repairability of therapist-client relationship</li> <li>• therapist and client not discussing client's expectations related to unsuccessful therapy</li> <li>• client's terminating of therapy a form of escaping</li> <li>• consequences of client terminating therapy on client's therapy journey</li> </ul>

Interview # 11	
Questions/Prompts	Emerging Categories
<ul style="list-style-type: none"> <li>• Tell me about your unsuccessful therapy experiences.</li> <li>• Do you remember if you had any kind of expectations for the group therapy?</li> </ul>	<ul style="list-style-type: none"> <li>• lack of follow-up after group therapy related to unsuccessful therapy</li> <li>• time-limited therapy related to unsuccessfulness</li> <li>• therapist disappears</li> <li>• qualities of therapist necessary for successful therapy</li> <li>• client's internal attribution for unsuccessful therapy related to symptoms of depression</li> </ul>

## **CHAPTER SIX:**

### **IMPLICATIONS OF THIS STUDY**

The ‘Client’s Helical Path,’ the theoretical model produced through the current study, contributes in significant and meaningful ways to the existing psychotherapy literature and has the potential to positively influence and inform an optimal clinical practice. It is my sincere hope that this research will, ultimately and in some manner, prove to be of direct benefit to the consumers of psychotherapy, the clients, in whose voices this theory is well grounded. I will first discuss areas of overlap between the Client’s Helical Path and the existing literature, as well as the unique nature of the current theory, and then turn to present the utility of its application in clinical practice. I will identify limitations of the theory, as well as suggest directions for future research within this content area.

#### **6.1 Areas of Overlap**

The existing psychotherapy literature<sup>17</sup> provides support for each of the four categories (Familiarity, Embarking, Evaluating, and Ending) of the Client’s Helical

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<sup>17</sup> The electronic citation database, *PsycInfo*, was utilized to explore the existing literature. All publication dates were selected, and key words used in various searches included: unsuccessful, therapy, client, patient, journey, path, expectations, desires, preferences, evaluations, endings, termination, familiarity.

Path, generally, as well as to many of the properties that define these categories. Having not previously reviewed most of the supporting studies that I am about to present, I found the overlap of thought, and even specific language, between the existing literature and the current theory under discussion quite striking. Such an observation not only provides support for the credibility of the theory, but also, given that the theory is grounded in the voices of clients, emphasizes the importance of utilizing clients as a primary source of data in psychotherapy research.

When Draucker and Petrovic (1997) asked adult male survivors of childhood sexual abuse to provide suggestions or recommendations to therapists working with this population, a common theme in the participants' responses was that a therapist's role is to provide direction and to be a guide for the 'healing journey' of the client. Draucker and Petrovic stated that participants made frequent references to their experiences of traveling along a therapeutic "road," "path," and "journey" of healing, which resonate with the core category of the current theory, the 'Client's Helical Path'.

The Client's Familiarity has properties of experience and understanding, which necessarily increase over the course, or time continuum, of movement along the Client's Helical Path. The current theory emphasizes that 'novice clients' bring with them both a lack of experience and a lack of understanding of the therapeutic enterprise. Moreover, understanding of therapy is not necessarily explicitly provided to them by either the first therapist with whom they work, as a novice client, or therapists with whom they work in later courses of therapy.

Based on the speculation that clients' unrealistic expectations for the content, process, and roles of therapy are likely to produce unsuccessful therapy experiences,

Zwick and Attkisson (1985) explored the utility and effectiveness of providing to clients a pretherapy orientation session. They provided the orientation protocol on a videotape, which described the therapist-client relationship, encouraged attendance of therapy appointments, and provided information that most therapy clients experience a reduction in anxiety and depression. Clients who viewed the videotape were found to report fewer symptoms at a one-month follow-up than clients who did not have this pretherapy ‘training’ experience provided to them. Zwick and Attkisson suggested that although a videotape format has advantages of easy administration and low cost, it may be more advantageous to present such information through in-person interviews that would promote greater client participation.

Glass, Arnkoff, and Shapiro (2001) made connections among clients’ previous, current, and future therapy experiences, which is a virtual rarity in the literature. They suggested that:

A therapist whose style is different from the client’s previous therapy can explain how he or she works. On the other hand, a therapist whose style may be perceived by the client as similar to a previous, unsatisfactory therapist can either take the opportunity to provide a rationale for this approach or can refer the client elsewhere before therapy gets underway. (p. 460)

One further possibility, of course, is for the therapist to adjust or adapt his or her approach to create a better fit with the client’s expectations and preferences (see also Al-Darmaki & Kivlighan, 1993 and Worthington & Atkinson, 1996), to avoid recreating

for the client a current therapy experience that resembles too closely a previous unsuccessful therapy experience.

Embarking represents the initial process for the client within a particular course of therapy, but it is a recurring process that the overarching helical path revisits and contextualizes. The process of Embarking presupposes that clients enter therapy with a particular mindset, and has properties of their desires, feelings, and the therapist-client communication about that mindset.

The concept of ‘client mindset’ upon embarking on a course of therapy has been focused upon by studies that have examined the ‘readiness’ of the client to engage in therapy (e.g., Howells & Day, 2003) and studies that have examined the ‘stage of change’ of the client at the time of entering therapy (e.g., Prochaska & Norcross, 2001; Satterfield, Buelow, Lyddon, & Johnson, 1995; Smith, Subich, & Kalodner, 1995). The client’s mindset, in the current theory, includes the expectations, preferences, and feelings of the client as she or he begins a new therapeutic experience. As also represented in the existing literature, the client’s mindset has significant implications for subsequent evaluations of therapy as either successful or unsuccessful, and for decisions about whether to continue or to terminate therapy. Further, both the current theory and the existing literature are clear that the expectations, preferences, and feelings of clients change over time; they are not rigidly fixed. Rogers (1951) stated that

the manner in which the client perceives the counselor and the interview is initially influenced very deeply by his expectations. . . . It is evident that clients come with widely varying expectations, many of which will not match the

experience they meet. Nevertheless, the expectation will govern their perception to a considerable extent. (pp. 66-68)

As part of their set of desires, clients hope that there will be a shared understanding with their therapists about the issues to which they need to attend and to focus upon in their therapeutic work together. Kantor and Kupferman (1985) proposed that clients perform covert interviews of their therapists in the early stages of a course of therapy, through which they attempt to establish the rules and guidelines for the therapy process, attempt to determine whether or not there is an adequate therapist-client 'fit,' and attempt to evaluate whether it is plausible that their therapists will be capable of helping with the most deep and personal of issues. When clients do not perceive that their therapists are 'on the same page' as them, they come to view the therapists as confused, and the therapies as confusing. Regardless of whether therapists are 'correct' about the issues of central therapeutic importance, it is clients' unmet expectations for a shared understanding that they relate to subsequent evaluations of therapy as unsuccessful. Clients expect that, in the event that they and their therapists do not find themselves on the same "wavelength," at very least there will be a willingness on the part of the therapist to respect and understand the client's perspective.

Reis and Brown (1999) advanced the argument that divergence between the expectations of the client and those of the therapist increases the probability that the client will evaluate therapy eventually as unsuccessful, who will likely choose to terminate. They stated that:



just as therapists expect clients to come in with problems, they should expect them to bring different perspectives. Just as clinicians' training and experience provide them with expertise about treatment, clients' unique experiences provide them expertise about their lives. UT [unilateral termination] is minimized when perspective divergence is expected, recognized, acknowledged, and incorporated into the process. (p. 132)

Glass, Arnkoff, and Shapiro (2001) performed a review of the literature with respect to the relationship between therapy outcome and the various expectations and preferences held by clients. The expectations held by clients, which can have positive, negative, or ambivalent valences, have been described as relating to both therapy outcome and the therapy process, including role expectations for therapists and themselves (see also Satterfield, Buelow, Lyddon, & Johnson, 1995). The authors note that particular difficulty can arise within the therapeutic relationship when a client's role expectations of the therapist are incongruent with the therapist's theoretical orientation. Glass et al. cited previous research that nearly three quarters of clients enter (or embark upon) therapy with a lack of clarity about the therapist's and their own roles in the encounter.

Glass et al. (2001) distinguished between clients' expectations and their preferences for therapy. The latter term, which has received much less attention in the literature than the former, implies the desires that clients hold. It is possible for clients to hold certain preferences, or desires, for their therapy or therapist, without simultaneously holding corresponding expectations. Three types of client preferences, or desires, have

been identified in the literature to date: role preferences, preferences for type of psychotherapy, and preferences for demographic features of the therapist.

In terms of the application of this knowledge to clinical practice, Glass et al. (2001) suggested that therapists need to explicitly assess and discuss clients' outcome and role expectations. When therapists discover inaccuracies or discrepancies in clients' expectations, they must address and correct these too. Glass et al. pointed to clients' inexperience (or lack of familiarity) with therapy as a potential source of inaccurate or discrepant expectations. After discovering a dearth of research addressing client preferences, Glass et al. speculated that perhaps therapists are not paying sufficient attention to their clients' preferences, or desires. As with expectations, client preferences are also worthy of explicit evaluation at the outset of a course of therapy. Glass et al. suggested that therapists come right out and ask their new clients, "What do you want to see happen here?," and then make a concerted effort to address such preferences, to the extent possible and clinically indicated.

Evaluating is the second cyclically-related category of the Client's Helical Path, and has properties of laying blame and contextualizing. Clients continually engage in a process of evaluating their progress in therapy and, more importantly to them, the degree to which both the therapy and the therapist are meeting their desires, or expectations, which are present since embarking. Clients may make both internal and external attributions for their successes and failures in therapy. When clients evaluate their therapy as unsuccessful, they naturally give consideration to who or what was at fault. They may externalize blame to the therapists or the therapies, they may internalize blame and hold themselves accountable, or they may construct shared attributions for the

unsuccessfulness of their therapies, and point to a poor fit between themselves and either the therapies or the therapists. Strupp, Hadley, and Gomes-Schwartz (1977) suggested that therapists, too, naturally consider attributions for unsuccessful therapy, but they suggested that blaming the patient is not appropriate:

a competent therapist, it goes without saying, must be capable of understanding the client's perspective. The time is past when one could conveniently blame the patient for lack of therapeutic progress or exacerbations of various kinds. The term "negative therapeutic reaction" has frequently been used as an umbrella to shift responsibility from the therapist to the client, and to exonerate the former from responsibility for possible negative outcomes. If a patient voices grievances against the therapist and his techniques, it may be more than "negative transference"; indeed, the patient may be right! In any case, the occurrence of persistent dissatisfactions in the patient must be regarded as a danger signal of basic flaws in the patient-therapist relationship. (p. 128)

Ackerman and Hilsenroth (2001) emphasized that some 'negative process,' or damage to the therapist-client relationship, is likely in almost all therapeutic encounters, but that the theoretical orientation of the therapist has little bearing on this eventuality (see also Strupp, 1993).

Clients often externalize blame for their unsuccessful therapy experiences to a failure on the part of their therapists to be "on the same page" as them. This may take the form of clients perceiving that therapists are 'forcing' clients' stories into some

preconceived ‘mould’ with respect to the type or etiology of clients’ presenting problems thereby creating a faulty understanding of their “data.” Worthington and Atkinson (1996, p. 423) defined ‘etiology attributions’ as “a subset of general causal attributions defined as beliefs about the specific causal agents that act as antecedents to physical or mental illness.” They found that when clients perceive that their therapists hold etiology attributions similar to their own, clients are more likely to view their therapists as credible and approachable. Further, they suggested that

when confronted with etiology attribution differences between themselves and their clients, therapists have a choice of adjusting their own attributions or convincing their clients that the therapist’s beliefs will lead to the desired therapeutic effect. Substantial evidence seems to exist that there may be some benefit to explicitly adopting the client’s frame of reference during the early phases of counseling, as a means of enhancing counselor credibility (p. 427)

Kirsch (1990) conceptualized etiology attributions as part of the client’s larger “weltanschauung,” which he defined as “a view of oneself and the world,” sometimes referred to as a “personal paradigm.” It is the network of interlocking beliefs and assumptions (schemas), conscious and unconscious, through which new information is processed” (p. 113). Kirsch proposed that if the rationale for treatment put forward by the therapist does not fit with the client’s weltanschauung, there is a significant risk that the client will form negative expectations with respect to the outcome or utility of that treatment.

Clients may interpret behaviours of therapists in a manner that leads them to believe that the therapists are either disrespecting or rejecting them, and clients commonly offer such interpretations as attributions for unsuccessful therapy. Clients may also feel dismissed, minimized, and insulted by their therapists, and such feelings invariably give rise to an evaluation of therapy as unsuccessful. Such feelings may arise in a number of ways, but most often they emanate from the impact that a single comment of the therapist has on the client. Clients identify the unwillingness of therapists to process or accept responsibility for problems that arise between them over the course of therapy to be another cause for unsuccessful therapy.

Rhodes, Hill, Thompson, and Elliott (1994) identified that when therapists do not acknowledge, discuss, and attempt to rectify clients' perceptions or assertions of 'misunderstandings' that have occurred within the therapeutic relationship, they increase the likelihood of unsuccessful therapy ensuing. Rhodes et al. found that therapy misunderstandings occurred when

a client was engaged in a therapeutic task and the therapist did or did not do something that was a breach of what the client wanted or needed. In response to this therapist act, the client had negative feelings toward self or the therapist (p. 479).

In cases where such misunderstandings are not adequately resolved, clients tend not to perceive their therapists as open to discussing either the events giving rise to the misunderstanding or clients' reactions to the events. Regardless of whether or not clients

put their concerns on the therapeutic table, when clients perceived therapists to not respond appropriately to negative events, clients tended to immediately consider terminating and eventually did so.

Elliott (1985) developed a taxonomy of therapist responses that clients deemed not to be helpful, which is presented in Table 6-1. There is a strong degree of concordance between the elements of Elliott's taxonomy and the therapist actions and interventions that clients in the current study found unhelpful and frequently related to unsuccessful therapy. The nonhelpful therapist responses that Elliott (1985) categorized as 'misperceptions' and 'misdirections' highlight the importance of therapists and clients having a shared understanding of each other, and their work together. Clients in the current study frequently pointed to their experiences of feeling misunderstood by their therapists, with respect to both the content and process of the therapeutic interaction. The nonhelpful responses categorized as 'negative counsellor reactions' are manifestations of therapist qualities that clients neither desire nor evaluate favourably: being uninvolved, and being critical. Elliott's 'unwanted responsibility' cluster demonstrates both the expectations that clients have for the role of the therapist, and the dissatisfaction that clients experience when their therapists do not behave in accordance with these role expectations.

**Table 6-1**

**Nonhelpful therapist responses (adapted from Elliott, 1985, pp. 314-315)**

<b>Cluster</b>	<b>Subcluster</b>	<b>Prototypic example of client's experience</b>
<b>Misperception</b>	<b>n/a</b>	"She was putting it into a certain category of people that I have my problem with (women) and that's not really what the problem was about. It was off the track."
<b>Negative counsellor reaction</b>	<b>Uninvolved counsellor</b>	"She didn't want to become involved. It looked like she felt uncomfortable, and she didn't want to talk about it with me. Since it was the end of the session, she just wanted to get it over with."
	<b>Critical counsellor</b>	"He seemed to be attacking me. He made it seem like I was looking at my problem from a narrow, one-sided point of view."

**Table 6-1 (continued)**

<b>Cluster</b>	<b>Subcluster</b>	<b>Prototypic example of client's experience</b>
<b>Unwanted Responsibility</b>	<b>Inadequate counsellor response</b>	"I was waiting for a response that didn't come. (It was an) uncomfortable feelings - you know you're supposed to be talking. I wanted her to say something .... Transmit her understanding .... Let me know what to do next."
	<b>Counsellor pressure</b>	"Every time he paused I felt more and more uneasy. I felt uneasy again. I felt like I had to come up with something to say. I wish he would have asked me something else or said something about himself. He was running what I said through his mind I think."
<b>Repetition</b>	<b>n/a</b>	"It was something that I knew about; something that everyone knows about; it was the same old story."
<b>Misdirection</b>	<b>n/a</b>	"It didn't have anything to do with the topic per se. He did it just to make me feel good; I felt like I had to respond to it, and I didn't want to."



**Table 6-1 (continued)**

<b>Cluster</b>	<b>Subcluster</b>	<b>Prototypic example of client's experience</b>
<b>Unwanted thoughts</b>	<b>n/a</b>	“It was bothersome again. I didn’t want that to happen (to end up like my brother). He was asking me what I was going to do to guarantee that wouldn’t happen. I had to think about it again. It made me want to not think about it at all, that whole situation.”

Just as Embarking represents the process of entering a particular course of therapy, Ending represents the process through which clients exit from their work with therapists. Although Ending is an expected, or natural, developmental process of the client's helical path, in the context of clients who have had unsuccessful therapy experiences, endings typically have a highly negative valence assigned. Ending comprises properties of means and shifts.

The means of endings are the ways in which clients’ courses of therapy are terminated. The decision to end the working relationship between therapist and client is, at times, made by the therapist. Clients often experience such maneuvers as lacking a consultative or collaborative quality, and consequently perceive their therapists’ decision as unilateral in nature. This one-sided (in this case, therapist-centered) move toward termination has been described in the literature, but only with the client as the “unilateral terminator” (see Reis & Brown, 1999).

Quintana and Holahan (1992) found a difference between the activities associated with therapists' termination of successful therapy cases and those associated with their termination of unsuccessful cases. With respect to termination of the latter type, therapists tended to perform less review with clients of their work together, to not work as hard to achieve 'closure' of the therapeutic relationship, to limit their discussions with clients about feelings associated with termination, and to focus less on preparing the client for the eventual termination. Hoyt (1993, p. 536) suggested that "when a patient quits treatment it may be more useful [for the therapist] to ask "What should I have done differently?" rather than wonder why the patient finally declined more of the same."

Unsuccessful therapy experiences, whether giving rise to or being defined by the process of ending, have a profound effect on clients' experiences of continuing to become more familiar with the enterprise of therapy and with the thoughts and feelings about continuing to move along their helical path. Cramer (1999) found that it is more likely that clients will entertain as a consideration, or actively seek out therapy experiences when they hold positive attitudes about the enterprise of therapy. Given that attitudes are, at least in part, shaped by our experiences, it is a logical extension that clients' past therapy experiences, mediated by their ensuing attitudes, implicate whether or not they will seek out future therapy services.

Many clients are able to tease apart their evaluations of one or more therapy experiences as unsuccessful from their more global evaluations of the enterprise of therapy. Other clients do not make, or are no longer willing to entertain, such a distinction. Such clients have had a sufficiently noxious single unsuccessful therapy

experience that they are no longer willing to move further along their helical path. Endings that are predicated upon, or produce, clients' feelings of significant disappointment, often relating to their evaluations that their expectations for therapy were not met, have the potential to turn clients away from considerations of future therapy.

Strupp, Hadley, and Gomes-Schwartz (1977, p. 138) stated that "the ultimate negative effect of an unsuccessful therapy experience is a patient's total rejection of therapy as a source of help" (see also Strupp & Hadley, 1985), which is the type of shift represented in Figure 4-1 as a dashed arrow projecting on a tangent away from the smooth turns of the helical path. Strupp (1990) proposed that:

[when clients'] early life experiences have been so destructive that human relatedness has failed to acquire a markedly positive valence and elaborate neurotic and characterological malformations have created massive barriers to intimacy (and therefore to "therapeutic learning"), chances are that psychotherapy either results in failure or at best in very modest gains. (p. 644)

I suggest that we can also conceptualize the "early life experiences" to which Strupp referred as "previous psychotherapy experiences." In both frames of reference, the past experiences of the client, whether "early" or "therapy-situated," lead to compromised or failed future experiences.

## **6.2 Unique Nature of the Theory**

As stated in the introductory chapter, there is a dearth of information in the existing psychotherapy literature with respect to unsuccessful psychotherapy. More than five decades ago, Rogers (1951, p. 188) lamented psychotherapy researchers' "inability to profit in a research way from our [therapy] failures." He suggested that this inability may be due, at least in part, to a lack of 'significant hypotheses' regarding such failures. To date, the predominant contributions to the literature in this content area have come from efforts to elucidate the causal factors that give rise to the 'negative outcomes' in therapy. Almost without exception, it has been researchers who have adopted assumptions consistent with a positivist or postpositivist paradigm of inquiry that have undertaken such investigations. Such philosophical positions, of course, give rise to a "find it and fix it" research approach, which, without doubt, has some merit.

I have identified two primary gaps in the existing psychotherapy literature, with respect to clients' experiences of unsuccessful therapy, that I believe my theory of the 'Client's Helical Path' helps to fill in. First, the existing literature tends to focus on 'negative outcomes' rather than 'unsuccessful therapy.' Related to this, and in part providing some explanation for it, the literature also tends to give primacy to the perspectives of therapists, rather than to the perspectives of clients. Second, the existing literature tends to decontextualize negative or unsuccessful experiences from the larger path, journey, or life of the client. I will address both of these gaps, and the ways in which my theory helps to ameliorate such deficits in the literature.

Mohr (1995) conducted the most recent comprehensive critical literature review with respect to 'negative outcomes' in psychotherapy (previous reviews cited widely

have included Smith, Glass, & Miller, 1980 and Strupp, Halley, & Gomes-Schwartz, 1977). Mohr examined patient, therapist, and therapy variables that researchers had hypothesized, and then substantiated, as having relationships to negative therapy outcomes with nonpsychotic adult clients. He stated that the purpose of reviews such as his are to enable clinicians “to learn to identify patients who are at risk for deterioration in psychotherapy to safe-guard the well-being of the patient” (p. 1). Notwithstanding the somewhat paternalistic flavour of this statement, it generally seems to be a laudable goal.

Patient variables found to be related to ‘negative outcomes’ include diagnosis and presentation (with special attention given to patients with borderline personality disorder), interpersonal functioning, severity of symptoms, and initial expectations for the process and for the duration of treatment. Therapist variables include lack of empathy, countertransference, underestimating the patient’s degree of pathology, and level of therapist experience. Process variables found to be related to ‘negative outcomes’ include therapist techniques and therapeutic modalities.

However, because the vast majority of studies in this literature utilize the received hypothetico-deductive methodology, it is therapist-researchers who have operationalized what constitutes a ‘negative outcome,’ and subsequently determined how they will measure it, based on the constructed operational definition. Of the 42 studies reviewed by Mohr (1995), only 3 appear to include patient reports about their therapy experience (e.g., client reports about therapist warmth, therapist empathy, and client anxiety associated with treatment), and these were three of the most dated studies included in the review (as reported by Mohr, 1995: Sloane, Staples, Cristol, Yorkston, &

Whipple, 1975; Strupp, Wallach, & Wogan, 1964; and Truax et al., 1966). The vast majority of studies reviewed by Mohr focused solely on whether the patient met some researcher-chosen and researcher-evaluated marker, or criterion, thus qualifying the ‘case’ as a ‘negative outcome’.

Strupp, Fox, and Lessler (1969), who were among the first to attempt to determine specific reasons for some clients’ disillusionment with psychotherapy (see also, Strupp, 1993), recognized the important distinction between ‘negative outcomes’ and ‘client dissatisfaction:’

Individuals who expressed dissatisfaction with their therapy were not necessarily therapeutic failures by other criteria, but it would be difficult to take issue with their felt disappointment in the value of psychotherapy. A self-evaluation is an index in its own right. Whether it should be taken at face value is, of course, another matter. (p. 103)

Although they expressed doubt about the prudence (or, perhaps, ‘validity’) of taking clients’ self-evaluations about their therapy “at face value,” Strupp, Fox, and Lessler (1969) were highlighting what continues to be a core gap in the psychotherapy literature. Researchers have tended to be quite presumptuous, assuming that they know better than clients what constitutes a ‘negative outcome’ or an ‘unsuccessful therapy experience.’ In contrast, I built my theory of the ‘Client’s Helical Path’ upon clients’ own definitions and constructions of what unsuccessful therapy is, or means to them. No preconceived definition of unsuccessful therapy was forced upon client-participants, or

otherwise presented to them. To have done so would have had the undesirable effect of constricting and delimiting the data that I gathered, which would have propagated, rather than ameliorated, this particular gap in the literature.

The existing literature demonstrates an overwhelming bias in favour of the perspectives of therapists, and against the perspectives of clients. Of the 42 studies reviewed by Mohr (1995), only 11 included any form of ratings by clients. The balance relied upon therapist and/or external observer perspectives for evaluating the nature and quality of the ‘negative outcomes,’ as well as for evaluating the causal variables hypothesized to give rise to such outcomes.

In 1951, at a time when psychotherapy research was beginning to blossom, Rogers observed that:

As our experience has moved us forward, it has become increasingly evident that the probability of therapeutic movement in a particular case depends primarily not upon the counselor’s personality, nor upon his techniques, nor even upon his attitudes, but upon the way all these are experienced by the client in the relationship. (p. 65)

I do not understand why the past 50 years of research have not, to a much greater degree, built upon Rogers’s observation. Bowman and Fine (2000) pointed to the disappointing fact that, even with the development of social constructionist models of therapy, which advocate the empowerment and value of the client’s perspective, corresponding literatures, which we would logically expect to give more weight to client

perspectives continue to give primacy to the views of therapists. Having assumed a feminist position, they suggested that:

The underrepresentation of client perceptions in the therapy literature has important implications about power because it supports dominant discourses that ascribe greater authority to the therapists than to clients. (p. 307)

Bowman and Fine (2000) characterize the literature on client perceptions of therapy as “relatively new,” a reality that is both inexcusable and perplexing, given that Rogers, half a century earlier, stated that “the way in which the client perceives or experiences the interviews is a field of inquiry which is new and in which the data are very limited” (p. 65).

Explicit calls for increased focus upon clients’ experiences of psychotherapy are more recently being made with greater frequency and conviction from an increasing number of therapist-researchers (to name but a few: Anderson, 1996; Bachelor, 1995; Bowman & Fine, 2000; Draucker & Petrovic, 1997; O’Neill, 1998; Rennie, 1992). In part, this may be due to greater awareness (and acceptance) that views of psychotherapy processes among clients, therapists, and observers vary widely (e.g., Mintz, Auerbach, Luborsky, & Johnson, 1973; Ogrodniczuk, Piper, Joyce, & McCallum, 2000; Shaw 1999a). Further, Ogrodniczuk, Piper, Joyce, and McCallum (2000) have found that clients’ perceptions of the ‘therapeutic alliance’ are a better predictor of psychotherapy outcome than are the perceptions of therapists. They suggested, therefore, that therapists



need to at least understand the perceptions of clients, regardless of whether or not they agree with them, in order to facilitate optimal outcomes.

Aside from optimizing therapy outcomes, Howe (1993) suggested that we need to give the voices of clients a much wider audience because they lend themselves to valuable sources of information and understanding with respect to the enterprise of psychotherapy. He stated that:

we soon discover that starting with the client's perspective provides us with a number of benefits and one or two surprises. The views of clients create a much simpler picture. They offer a single experiential view and a common account of their experiences whatever the psychotherapeutic orientation of their counsellor. Generally, findings which are regular and crop up in a variety of situations often hold the key to a deeper understanding of what is going on. I shall argue that the regularity and relative simplicity of the client's view provides us with powerful and telling evidence about the nature of psychotherapy and the human relationships that go with it. (p. 2)

Macran, Ross, Hardy, and Shapiro (1999) proposed evidential, political, and conceptual rationales for psychotherapy researchers to give clients' perspectives, or voices, greater, if not primary consideration. They suggested, quite appropriately in my opinion, that "if the ultimate aim of psychotherapy research is to improve the experience and outcome of therapy for clients, then surely it is appropriate and necessary for clients

to identify what they feel is important in their therapy.” (p. 333). Macran et al. stressed that three principles must guide a shift toward ‘taking clients’ perspectives’:

- (1) A *recognition* by researchers that clients are individuals with their own beliefs and values who make an active contribution to the therapeutic process;
- (2) Translating that recognition into *action* by allowing the individual nature of clients’ experiences to be expressed in a way which is unhindered by researchers’ own beliefs and values; and
- (3) Not merely requiring clients to complete rating scales or checklists about their feelings or experiences. By this definition, the majority of outcome and evaluative researchers would be able to claim that they consider clients’ perspective already. Instead we suggest a collaborative approach, which allows clients scope to set the agenda for what is important and meaningful for them personally in therapy. (p. 325).

I concur wholeheartedly with Howe (1993) and Macran et al. (1999). For decades, psychological researchers have been advocating that we give the voices of clients a focal audience. Studies such as the current one, along with others in very recent years (e.g., Anderson, 1996; Bachelor, 1995; Bowman & Fine, 2000; Draucker & Petrovic, 1997; Elliott, 1985, 1986; Elliott & Shapiro, 1992; Glass, Arnkoff, & Shapiro, 2001; Hill, Thompson, Cogar, & Denman, 1993; Howe, 1993; Kagan & Kagan, 1991; Kantor & Kupferman, 1985; Macran, Ross, Hardy, & Shapiro, 1999; Mintz, Auerbach, Luborsky, & Johnson, 1973; Ogrodniczuk, Piper, Joyce, & McCallum, 2000; O’Neill,

1998; Quintana & Holahan, 1992; Reis & Brown, 1999; Rennie, 1990, 1992, 1994; Rhodes, Hill, Thompson, & Elliott, 1994; Satterfield, Buelow, Lyddon, & Johnson, 1995; Shaw, 1999a; Shaw & O'Neill, 1997; Todd, Deane, & Bragdon, 2003; Worthington & Atkinson, 1996), are beginning to fill in this gap in the literature. Unfortunately, there still are no theories in the existing psychotherapy literature, grounded in clients' evaluations and reports, that represent clients' experiences of unsuccessful psychotherapy. Consequently, my theory of the Client's Helical Path makes an important contribution to this body of knowledge. Paying close attention to the client's perspective not only demonstrates our willingness to make a long overdue shift in the power dynamic between therapists and clients, but it also makes good clinical sense. In the following section, I will discuss further the clinical utility of paying such attention to clients' perspectives on unsuccessful therapy.

Mohr (1995) found in his recent review of the psychotherapy literature that the length of clients' exposure to treatment, or the unit of analysis, examined by researchers varies from a single session, to blocks of up to 20 sessions, to entire courses of therapy. This finding is consistent with my own review of the literature (see, for example, Elliott & James, 1989 and Rennie, 2002) and, in my opinion, having a full course of therapy as the upper limit of the length of the unit of analysis represents another serious gap in this body of knowledge. I propose that such limits on the length of the unit of analysis have come about due to researcher-imposed criteria for and definitions of unsuccessful therapy, aggravated further by the limited audience given to the voices of clients. The returns from the current study clearly indicate that when we not only permit, but invite, clients to define for themselves the meaning of 'unsuccessful therapy,' and we provide

them with the much deserved audience to hear their related experiences, clients set the length of the unit of analysis at multiple therapy experiences.

Because investigations to date, even when using the widest scope, have investigated no larger than a ‘course of therapy’ unit of analysis, they have necessarily decontextualized the returns from these investigations from the lived, holistic experiences of clients. Keeping the unit of analysis to no more than a course of therapy, when investigating the impact of unsuccessful therapy, implies an assumption that experiences prior to those under investigation do not influence ‘negative outcomes,’ and that ‘negative outcomes’ do not influence experiences that come after those under investigation. I reject such assumptions.

Heatherington (1989) expressed concern about the tendency of psychotherapy researchers to rely on approaches that run the risk of “stripping” the client’s behaviour from its context, which compromises the ability to interpret the meaning of that behaviour. The theory of the ‘Client’s Helical Path’ provides a contextualized understanding of clients’ experiences of unsuccessful therapy over multiple therapy experiences that span the past, present, and future therapy lives of clients. Moreover, it provides an understanding of how the client’s previous therapy experiences may influence her current course of therapy, and how her experience of the current course of therapy may, in turn, influence her future therapy experiences. This reframed unit of analysis, I believe, is likely the most substantial and important contribution to the literature offered by the current research, as it represents a frame of reference not previously considered in this body of knowledge. Interestingly, and fittingly, this contribution is solely attributable to the content of the voices of clients.

### **6.3 Utility of the Theory**

Since writing up the theoretical representation of the Client's Helical Path, I have begun exploring its utility in my clinical practice. I have found that it provides me with another dimension that I may and, I suggest, need to use in my understanding of clients with whom I work. Knowledge of this theory encourages me to take into consideration my clients' previous experiences with psychotherapy, and to recognize how such prior experiences are influencing their work with me.

All clients (including novice clients) come to me with a certain mindset, comprising both their desires for and feelings about therapy. All clients will make some evaluation of the successfulness or unsuccessfulness of their therapeutic work with me. And my work with all clients will, at some point, end. Through our work together, clients will become more familiar with the enterprise of therapy than they had been upon embarking upon the current course of therapy. Later, my clients will likely continue to travel along their helical path, but our work together will, to some extent, shape their future experiences. That, indeed, challenges me to acknowledge that the manner in which I conduct myself in the present will have some impact on the client's experiences in the future.

Conducting this study and ultimately constructing the theory of the 'Client's Helical Path' has changed the 'unit of analysis,' in a clinical context, through which I understand clients. Prior to developing this theory, it was my clinical practice to ask new clients about their prior treatment experiences during the course of my standard intake interview. My training and experience informed me that this was useful information to gather, along with information about prior diagnoses, family history of mental illness,

etc. However, I approached the question of previous therapy experience as an exercise in fact gathering, one that would allow me to comprehensively document the relevant history of the client. Consequently, with that frame of reference, I merely charted the information provided (typically limited to dates and types of treatment), but did not explore the meaning that clients had assigned to this dimension of their histories. As I now look back, after integrating my new knowledge gleaned from this research, it is hard for me to imagine that I overlooked exploring the meanings that clients assign to these past experiences.

In my recent experience applying the theoretical understanding offered by the ‘Client’s Helical Path’ to my work with clients, responses from clients have been quite positive and affirming that the theory ‘fits’ with their experiences and understanding of the path they travel. Of course, I recognize my bias: I am motivated to have the theory in which I have great personal investment turn out to have practical utility. And, I recognize the power differential in the therapeutic relationship, which has the potential to influence clients to ‘smile and nod,’ externally, even when they are confused or objecting, internally.

Nonetheless, my experience working with clients has allowed me to recognize certain verbal and nonverbal ‘signs’ from clients when they are feeling validated by something occurring between us. I have regularly noticed such ‘signs’ of validation as I (briefly) discuss the elements of the ‘Client’s Helical Path’ with each new client during our initial session. I let clients know that I understand that they have certain expectations or desires for what will happen in our work together, and that such a mindset is not

limited to changes they wish to make in themselves, but extends to the quality of the time that we spend together.

In the case of novice clients, I affirm that it can be confusing to come into a new setting, with a new person, and not know where to start. With more experienced clients, I suggest that there were likely aspects of their previous therapy experiences with which they were satisfied, and perhaps some with which they were less satisfied. I do not solicit names of other therapists, or any other identifying information, because my intent is not to snoop into other therapy rooms. I stick to the client's experiences, because that is what I am informed to do by the theory.

I tell clients that I am not a mind reader (which usually elicits an ice breaking chuckle), and invite them to let me know what they expect from me, and from therapy, and let them know that they may change their expectations at any time. I tell clients that I understand that they will be evaluating their satisfaction with our work together, and that they may find themselves feeling dissatisfied with me, or with the therapy. I request that in such cases clients talk to me about their feelings, but also let them know that they always have the option to just not show up. That is their choice.

I believe that I am providing a higher quality service to clients as a result of developing an understanding of, and applying the knowledge provided in, the theory of the 'Client's Helical Path'. Can I substantiate my claim of improved service? No, not yet. However, on a process level, I am utilizing knowledge generated from those to whom I am attempting to provide an optimal service. Logically, at least, it seems that such an approach has a greater probability of delivering a satisfactory product than does

a service based on knowledge generated from some other group (such as therapist-researchers).

I have presented my theory to several colleagues, across different clinical sites. They have, to me at least, commented that the theory fits and works with their understandings of clients. They have also commented, though, that they had not previously considered systematically conceptualizing clients' experiences with therapy across multiple, interconnected therapy encounters, spanning the past, present, and future. Thus, similar to my own experience in constructing and applying the theory, the 'Client's Helical Path' has created one of those memorable "ah-ha" experiences for both my colleagues and our clients. I take that as a positive indicator of the utility of this theory.

#### **6.4 Limitations**

It is my perception that, with respect to my necessary role of hermeneut, analyst, and grounded theorist, I present the most notable limitation to the validity and, therefore, utility of the theory. Although I attempted to be as reflexive as I could, from the very start of this process, I cannot say with certainty that I do not hold assumptions and biases that are out of my awareness and, therefore, were not put on the table but did influence my construction of the theory. Of greater concern, likely, is my novice status with respect to the reliance on a grounded theory methodology, and the related possibility that I made procedural and/or conceptual errors due to a lack of experience or understanding.

I do not offer apologies for the admittedly limited generalizability of these results, because to do so would imply that generalizing the results is an appropriate and



recognized goal for a grounded theory study, which it certainly is not. I have, however, attempted to present a transparent account of the theory generation process, including a “thick” description of the theoretical representation of the ‘Client’s Helical Path,’ to enhance readers’ ability to make valid ‘case-to-case transfers’ (see Firestone, 1993) from the returns of this research to their own contexts. Moreover, I have presented in Chapter Five the returns from three different ‘exercises in self-scrutiny’ that, along with the research process journal presented in Chapter Three, I hope will both facilitate readers conducting credibility checks of my work, and will clearly demonstrate that I have attempted to be reflexive and cautious throughout the research process.

## **6.5 Future directions**

As stated previously, there is a significant, disappointing, and indeed embarrassing dearth of studies in the psychotherapy literature that have relied upon the voices of clients as a primary source of data. Future studies must rectify this deficit, in deliberate rather than incidental fashion, to demonstrate value for the knowledge and wisdom of clients, as well as to appropriately relinquish, or at least bring into balance, the long-held power and control of therapist-researchers. Therapist-researchers have made calls to do so for decades, but the research community has been slow to respond in an adequate manner.

Further, much more research is needed with respect to the specific content area of unsuccessful therapy. As with the matter of attention being paid to the voices of clients, so too have leading researchers advocated for investigations of therapeutic failures as a means to both enhance our knowledge and optimize our practice. So too,

unfortunately, the research community has not responded. Perhaps an investigation of therapist-researchers' apparent reluctance to delve into this domain is in order.

Particular research questions that intrigue me, at this way point along my research path, include:

(1) How robust is the theory of the 'Client's Helical Path,' with respect to particular clients (including those who have only experienced successful therapy), therapists, therapies, or therapy setting?

(2) What is the impact on clients of having this theory, purportedly representing their own experiences, brought explicitly into the therapeutic discourse? What is the impact on therapists?

(3) What other therapy experiences could we conceptualize as extending across multiple therapy experiences?

(4) What categories and associations relevant to clients' experiences (both successful and unsuccessful) of psychotherapy are missing from the current theoretical representation, or need revision?

Given my particular philosophical assumptions, as stated in Chapter One, it is my intention to continue to utilize the grounded theory methodology, incorporating a methodical hermeneutic interpretation, in my future research ventures. Although I have historically been drawn toward challenging undertakings, I did experience this first foray into the grounded theory methodology as overwhelming and confusing, at times. Such an experience, I believe, increases the probability that the novice grounded theorist will

not create methods, or utilize procedures, that are optimally consonant with the methodological principles.

For that reason, I believe there is a need to produce more writings on grounded theory methodology specifically designed for the novice grounded theorist, to highlight as many concrete examples or suggestions as possible, and to balance against the plethora of abstract elements contained therein. One starting point might be to develop a mechanism for maintaining and sharing our research process journals, which document our common struggles with methodology and method and, therefore, have the potential to provide each other with both encouragement, innovation, and validation.

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## APPENDIX A

### RECRUITMENT ADVERTISEMENT

***Have You Experienced ....***

◆ **UNSUCCESSFUL** ◆  
◆ **Therapy ???** ◆

Adults are invited to participate in a research study about their past experiences of unsuccessful talk therapy. Interviews are expected to last two hours.

***For more information contact :***

***Stephen Shaw, Psychology Dept.***

***Email : [stephen.shaw@usask.ca](mailto:stephen.shaw@usask.ca)***

***Phone : (306) 933-0444***



## APPENDIX B

### TELEPHONE SCREENING PROTOCOL

My name is Stephen Shaw, and I am calling in response to the message you left regarding the research study that was advertised in the paper. At this point, I'd like to describe the study in some more detail, so that you can decide whether you are interested in participating.

I am a Doctoral Student in the Psychology Department at the University of Saskatchewan, and I am currently conducting a research study which is designed to gain a better understanding of the experiences of clients who consider a past counseling or therapy experience to have been unsuccessful.

**Have you had a counseling or therapy experience in the past that you consider to have been unsuccessful?**

- *If YES, continue*
- *If NO, thank and terminate call*

**What type of counseling or therapy was this?**

- *If any type of "talk therapy," continue*
- *If not "talk therapy," thank and terminate call*

Participating in this study will involve meeting with me for approximately 1 to 2 hours for an interview, to discuss your experience of unsuccessful counseling or therapy. All of the information provided in the interview will be held in strict confidence. The interview will be audio taped, so that I can make sure that I accurately record all of the information that you would be providing to me. Afterward, I will be transcribing the interview, and removing all identifying information (including names, places, etc.) to



protect your anonymity. You will have an opportunity to review and comment on both the transcript and the final product, if you so choose. Of course, at any time you can withdraw from participating in the study and have all information you provided deleted and destroyed.

**Do you have any questions about what I've explained so far?**

**Are you still interested in participating in this study?**

- *If NO, thank and terminate call*
- *If YES, continue*

I will be conducting approximately two interviews per month from now until April. **May I contact you during that period to schedule an interview?**

Unfortunately, it will not be possible to interview all of the volunteers who have phoned. If you are not being asked to schedule an interview, I will call you to let you know. So, you will hear from me either way.

**Would you still like to be put on a list of people who may be contacted for an interview?**

You are completely free to change your mind about participating in this study at any time. If you have any questions in the meantime, please contact me at 966-XXXX.

Thank you.

## APPENDIX C

### CONSENT FOR PARTICIPATION

#### **Study of Clients' Experiences of Unsuccessful Therapy**

**Investigator:** Stephen C. Shaw, B.Sc.H. (Doctoral Candidate in Clinical Psychology)

**Supervisor:** Linda M. McMullen, Ph.D., Psychology Dept., Univ. of Saskatchewan

You are invited to participate in a study investigating clients' experiences of unsuccessful therapy. This study is the Investigator's Doctoral Dissertation research. Before you agree to participate, it is important that you have been told, and that you understand, the following information:

#### **Procedure:**

You are being asked to participate in one research interview with the primary investigator (Stephen Shaw). The interviews will take place at the Psychological Services Centre (PSC) at the University of Saskatchewan (Room 190, Arts Building). This interview will be audio taped, then transcribed. As the interviews are being transcribed, all identifying information (e.g., names, locations, etc.) will be removed to protect your identity. During these interviews, you will be asked to describe your experience of unsuccessful therapy or counselling. You will not be required to make any comments, or answer any questions, that you do not wish to. The interviews are expected to run between one and two hours in length.

You will be given an opportunity to review the transcript of your interview to ensure that it accurately reflects what you said, or intended to say. You will be able to make any changes to the transcript, and will be able to withdraw your transcript from the study, if you so desire. After you review the transcript, you will be asked to sign a

“Data/Transcript Release Form,” indicating that you are giving the researchers permission to use material (including direct quotes) from your interview/transcript. If you choose not to review the transcript of your interview, but still wish to give the researchers permission to use material (including direct quotes) from your interview/transcript, you will be asked to indicate this choice on the “Data/Transcript Release Form.”

**Risks and Benefits:**

There are no particular risks associated with your participation in this study. Nonetheless, you may find that the process of describing your unsuccessful experiences with therapy or counselling to be somewhat emotionally upsetting, at times. You are assured that the interviewer will be sensitive to this possibility, and will attend to your reactions in the interview in an appropriate manner.

You may experience some benefits from participating in this study. You will have the opportunity to talk openly and extensively to someone who wants to hear what your unsuccessful experiences with therapy were like. Many people find that such an opportunity to “be heard” is very rewarding.

Finally, the notion of unsuccessful therapy is not usually investigated from the perspective of clients. Therefore, your participation has the potential to assist in developing new knowledge about the processes and outcomes of therapy, and such knowledge has the potential to benefit other clients (and therapists) in the future.

### **Freedom to Withdraw:**

Your participation in this study is completely voluntary. At any time during your participation you may withdraw from the study. If you choose to withdraw, you will have complete control over all of the information that you have provided during your participation in this study: you may choose to have your information deleted and destroyed, or you may choose to have some or all of your information remain in the study. This choice is entirely yours to make.

### **Dissemination of Results**

The final product of this research will be a doctoral dissertation, produced and distributed in accordance with University of Saskatchewan policies and procedures. The results may also be used to inform the construction of books or journal articles, and may be presented at professional conferences.

### **Confidentiality:**

Absolute respect will be maintained for the confidentiality of the information that you provide. Your name will NOT appear on any documents (other than this form), including the transcript of your interview, the final write-up of this study, or any related publications or presentations of this research. Instead, all identifying information will be removed and codes will be used in place of any names, places, or other information that could possibly reveal your identity.

The audiotapes and transcripts of the research interviews will be stored safely and securely by Professor McMullen for a period of at least five years. Only those with ethical approval (e.g., the researcher, his supervisor, and research assistants) will be allowed access to the transcripts (which will have all identifying information removed).

The researcher will be bound by law to the standard limits to confidentiality. That is, if you indicated: (1) an intent to harm yourself, (2) an intent to harm another person, or (3) any information that a child, under the age of sixteen, was at risk for abuse or neglect, the researcher would be required to take appropriate steps, in an effort to keep all parties safe.

**Clarification & Feedback:**

You are encouraged to ask all questions that you have about any aspect of your participation, including this form, *at any time*. You are assured that your questions will be answered openly and honestly. You may raise any question or concerns that you have with Stephen Shaw (966-XXXX or 966-6700) or Dr. Linda McMullen (966-6700).

If you wish to receive a summary of the study, you may provide your mailing address for this purpose. You are also invited to provide any feedback that you may wish to offer on the content of that summary. Such feedback may be offered in either written or oral form (through a follow-up, post-study interview to be scheduled at a mutually agreeable time).

I understand that if I wish to clarify my rights as a research participant, I may contact the Office of Research Services, University of Saskatchewan (966-4053). I acknowledge that I have read the information above. I have had the opportunity to ask any questions, and have had those answered to my complete satisfaction. I understand that the researchers will advise me of any new information that could have a bearing on my decision to continue in this study. I have been given a copy of this form to keep. I now offer my consent to participate in this study.

---

**Participant's name (please print)**

**Participant's signature**

**Date**

---

**Researcher's name**

**Researcher's signature**

**Date**

## APPENDIX D

### DATA/TRANSCRIPT RELEASE FORM

#### *Study of Clients' Experiences of Unsuccessful Therapy*

#### CHECK EITHER BOX "A" or BOX "B"

- ☐ A. I, \_\_\_\_\_, have reviewed the complete transcript of my personal interview in this study, and acknowledge that the transcript accurately reflects what I said, or intended to say, in my personal interview with Stephen Shaw.
- ☐ B. I, \_\_\_\_\_, have been given the opportunity to review the complete transcript of my personal interview with Stephen Shaw in this study, and have chosen *not* to conduct a review of the transcript.

I hereby authorize the release of this transcript to Stephen Shaw to be used in the manner described in the Consent Form, which includes the use of direct quotes from my transcript. I understand that my name will never be disclosed by the researcher, as also described in the Consent Form. I have received a copy of this Data/Transcript Release Form for my own records.

\_\_\_\_\_

**Participant**

\_\_\_\_\_

**Date**

\_\_\_\_\_

**Researcher**

\_\_\_\_\_

**Date**